

## **Notice**

The official Plan Document that describes the benefits for which you are eligible under your group health plan is available, in print, in the department of your employer or group sponsor responsible for the administration of your health plan. A printed copy of the 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 employer or group 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 employer or group sponsor are not binding on Wellmark Blue Cross and Blue Shield of Iowa. In the event of any inconsistency or conflict between the printed 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

**Schuster Co., Group Dental 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

**BlueDental<sup>SM</sup>**

**Schuster Co.**

**NOTICE**

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



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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 employer or group sponsor.

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

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 *Pretreatment Notification* 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

<b>Plan Name:</b>	Schuster Co., Group Medical Dental Plan
<b>Plan Sponsor:</b>	Schuster Co.
<b>Employer ID Number:</b>	42-0933522
<b>Plan Number:</b>	502
<b>When Plan Year Ends:</b>	December 31
<b>Participants of Plan:</b>	See <i>Coverage Eligibility and Effective Date</i> later in this summary plan description.
<b>Plan Administrator and Agent for Service of Legal Process:</b>	Schuster Co. 2605 Lincoln Avenue SW Le Mars, IA 51031 Phone Number: 712-546-5124 Service of legal process may be made upon the plan administrator and/or agent.
<b>How Plan Costs Are Funded:</b>	Employer and employee contributions
<b>Type of Plan:</b>	Group Health Plan
<b>Type of Administration:</b>	Self-Funded
<b>Benefits Administered by:</b>	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.

Category	Deductible	Coinsurance	Benefit Year Maximum	Lifetime Maximum
<b>All Services</b>	\$50 per person \$150 per family*		\$1,000	
<b>Oral Evaluations</b>		20%		
Preventive Evaluations (check-ups)				
Problem-Focused Evaluations				
Dental Cleaning				
Fluoride Applications				
X-rays				
Periodontal Maintenance				
Therapy				
Sealant Applications				
Space Maintainers				
<b>Cavity Repair</b>		20%		
Contour of Bone				
Emergency Treatment				
General Anesthesia				
Limited Occlusal Adjustment				
Routine Oral Surgery				
<b>Root Canals and Other Endodontic Services</b>		50%		
Apicoectomy				
Direct Pulp Cap				
Pulpotomy				
Retrograde Fillings				
Root Canal Therapy				
<b>Treatment of Gum and Bone Diseases</b>		50%		
Conservative Procedures				
Complex Procedures				
<b>High Cost Restorations</b>		50%		
Crowns				
Inlays				
Onlays				
Posts and Cores				

Category	Deductible	Coinsurance	Benefit Year Maximum	Lifetime Maximum
<b>Dentures and Bridges (Prosthetics)</b> Bridges Dentures Dental Implants		50%		
<b>Orthodontics</b>	waived	50%	waived	\$1,000

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

## Payment Details

### Deductible

Deductible is the fixed dollar amount you pay for covered services in a benefit year before Blue Dental 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 coinsurance applies.

### Coinsurance

Coinsurance is the amount, calculated using a fixed percentage, you pay each time you receive covered services. Coinsurance amounts apply after you meet the deductible for the benefit year.

### Benefit Year Maximum

This is the maximum payment amount each member is eligible to receive for certain covered services in a benefit year. The benefit year maximum is reached from claims settled under this benefits plan during a benefit year.

### Lifetime Maximum

In a member's lifetime, total benefits are limited by a dollar amount for benefit category *Orthodontics*.

## 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 9. 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 Maximum.** This column lists maximum benefit amounts that each member is eligible to receive per covered service, benefit year, or lifetime. Service maximums that apply per benefit year or per lifetime are reached from claim payment amounts accumulated under this group health plan and any prior group health plans sponsored by your employer or group sponsor and administered by Wellmark Blue Cross and Blue Shield of Iowa.

Service Category	Covered	Not Covered	See Page	Service Maximum
<b>Alveoplasty (Contour of Bone)</b>	●		9	
<b>Anesthesia</b>			9	
General and Intravenous Sedation	●		9	
Local when billed separately from the related procedure		⊘	9	
<b>Apicoectomy/Periradicular Surgery</b>	●		9	
<b>Braces (Orthodontics)</b>			9	
Adults		⊘	9	
Children	●		9	
Repair or Replacement of Orthodontic Appliances		⊘	9	
<b>Bridges</b>	●		9	Once every five years per tooth.

Service Category	Covered	Not Covered	See Page	Service Maximum
Cavity Repair	●		9	
Cleaning (Prophylaxis)	●		9	Twice per benefit year.
Congenital Deformity		⊗	10	
Controlled Release Device		⊗	10	
Cosmetic Dental Procedures		⊗	10	
Crowns	●		10	Once every five years per tooth.
Dentures	●		10	Once every five years per tooth.
Drugs		⊗	10	
Emergency Treatment (Palliative)	●		10	
Fluoride Applications (Topical)	●		10	For eligible dependent children under age 19 once every 12 months.
Implants	●		10	Once in a lifetime per missing tooth.
Infection Control, if an additional fee		⊗	11	
Inlays	●		11	Once every five years per tooth.
Lost or Stolen Appliances		⊗	11	
Medical Services or Supplies		⊗	11	
Nondental Services		⊗	11	
Occlusal Adjustment			11	
Limited	●		11	
Complete		⊗	11	
Onlays	●		11	Once every five years per tooth.
Oral Evaluations (Preventive Check-Ups and Problem-Focused Evaluations)	●		12	Twice per benefit year.
Oral Surgery – Routine	●		12	
Periodontal Appliances		⊗	12	

Service Category	Covered	Not Covered	See Page	Service Maximum
<b>Periodontal Procedures</b>			12	
Conservative (Root Planing and Scaling)	●		12	Conservative periodontal procedures once every 24 months for each quadrant.
Complex	●		12	Complex periodontal procedures once every three years for each quadrant.
Periodontal Maintenance Therapy	●		12	During the 24-month period following initial conservative or complex therapy up to four times per benefit year.
<b>Posts and Cores</b>	●		12	Once every five years per tooth.
<b>Pulp Caps</b>			13	
Direct	●		13	Once per lifetime per tooth.
Indirect		⊘	13	
<b>Pulpotomy</b>	●		13	
<b>Retrograde Fillings</b>	●		13	
<b>Root Canals</b>	●		13	
<b>Sealant Applications</b>	●		13	For eligible dependent children under age 15. Once in a lifetime per permanent first and second molars.
<b>Space Maintainers</b>	●		13	For eligible dependent children under age 15. Once in a lifetime per quadrant.
<b>Veneers</b>		⊘	13	
<b>X-rays</b>			13	
Bitewing	●		13	Once every 12 months.
Full-Mouth	●		13	Once every five years.
Occlusal and Extraoral	●		13	
Periapical	●		14	



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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 15. If a service or supply is not specifically listed, do not assume it is covered.

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### Alveoplasty (Contour of Bone)

**Covered:** Reshaping and recontouring bone usually in preparation for tooth replacement appliances or performed in conjunction with the removal of a tooth or teeth.

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### Anesthesia

**Covered:** General anesthesia or intravenous sedation administered in connection with covered oral surgery when billed by the operating dentist.

**Not Covered:** Local anesthesia when billed separately from a related procedure.

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### Apicoectomy/Periradicular Surgery

**Covered:** Surgery to repair a damaged root as part of root canal therapy or correction of a previous root canal.

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### Braces (Orthodontics)

**Covered:** Services for proper alignment of teeth, including the following related surgical services:

- Exposure of impacted or unerupted teeth.
- Repositioning of teeth.

**Service Maximum:**

- Covered only for eligible dependent children who are at least age eight and under age 19.

**Not Covered:**

- Repair or replacement of orthodontic appliances (including related services or supplies).
- Adult orthodontics.

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### Bridges

**Covered:** Replacement of missing permanent teeth with a dental prosthesis that is cemented in place and can only be removed by a dentist. Bridge repairs are also included.

**Service Maximum:**

- Bridges are a benefit once every five years per tooth.
- Bridges that are supported by dental implants are limited to the amount paid for a bridge supported by natural teeth.

**See Also:**

*Pretreatment Notification*, page 19.

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### Cavity Repair

**Covered:** Pre-formed or stainless steel restorations and restorations such as silver (amalgam) fillings, and tooth-colored (composite) fillings.

**Not Covered:** The cost difference between a tooth-colored filling and a silver filling if the restoration is for a back (posterior) tooth.

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### Cleaning (Prophylaxis)

**Covered:** Removal of plaque, tartar (calculus), and stain from teeth.

**Service Maximum:**

- Twice per benefit year.

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## Congenital Deformity

**Not Covered:** Services or supplies for the correction of congenital deformities such as cleft palate.

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## Controlled Release Device

**Not Covered:** Services or supplies used for the controlled release of therapeutic agents into diseased crevices around your teeth.

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## Cosmetic Dental Procedures

**Not Covered:** Services or supplies that have the primary purpose of improving the appearance of your teeth, rather than restoring or improving dental form or function.

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## Crowns

**Covered:** Restoring tooth structure lost due to decay or fracture by covering and replacing the visible part of the tooth with a precious metal, porcelain-fused-to-metal, or porcelain crown when the tooth cannot be restored with a silver (amalgam) or tooth-colored (composite) filling.

### Service Maximum:

- Crowns are a benefit once every five years per tooth beginning from the date the indirect fabrication is cemented in place.
- If a filling was performed on the same tooth within the previous 12 months, the benefit for the crown will be reduced by the amount of the benefit paid for the filling.

**Not Covered:** Crowns that are not meant to restore form and function of a tooth, including crowns placed for the primary purpose of cosmetics, altering vertical dimension, restoring your bite (occlusion), or restoring a tooth due to attrition and abrasion.

### See Also:

*Pretreatment Notification*, page 19.

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## Dentures

**Covered:** Replacing missing permanent teeth with a dental prosthesis that is removable. Denture repair and relining are also included. Dentures that are supported by surgically placed dental implants are limited to the amount paid for a conventional prosthesis supported by natural teeth.

### Service Maximum:

- Dentures are a benefit once every five years per tooth.
- Relining is available only if performed six months or more after the initial placement of the denture and once every two years thereafter.

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## Drugs

**Not Covered:** Prescription or non-prescription drugs or medicines.

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## Emergency Treatment (Palliative)

**Covered:** Treatment to relieve pain or infection of dental origin.

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## Fluoride Applications (Topical)

**Covered.**

### Service Maximum:

- For eligible dependent children under age 19 once every 12 months.

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## Implants

**Covered:** Replacing a missing permanent tooth with a surgically-implanted dental prosthesis that is not removable by the patient. A restoration is then placed on the implant.

To be covered, implants must:

- Be an alternative to a fixed partial denture.
- Replace one or two missing teeth per arch (excluding a third molar).

- Reside between two natural teeth (excluding a third molar) for which a laboratory-processed restoration is not planned.

**Please note:** In addition to the preceding requirements, the bone structure supporting the implant must be of adequate density and sufficient height (minimum 10 mm) to support the implant.

Repairs for dental implants and restorations to dental implants are also covered.

**Service Maximum:**

- Implants are a benefit once in a lifetime per missing tooth.
- If three or more teeth are missing in an arch without laboratory-processed restorations, benefits are limited to the amount payable for a removable partial denture.

**Not Covered:** Services or supplies related to a non-covered implant procedure.

**See Also:**

*Pretreatment Notification*, page 19.

**Infection Control**

**Not Covered:** Separate charges for “infection control,” which includes the costs for services and supplies associated with sterilization procedures. Participating dentists incorporate these costs into their normal fees and will not charge an additional fee for “infection control.”

**Inlays**

**Covered:** Restoring tooth structure lost due to decay or fracture with a cast metallic or porcelain filling when the tooth cannot be restored with a silver (amalgam) or tooth-colored (composite) filling.

**Service Maximum:**

- Available once every five years per tooth beginning from the date the indirect fabrication is cemented in place.
- Benefits are limited to the amount paid for a silver (amalgam) filling. You are

responsible for any difference in cost between a porcelain filling and a metallic filling.

- If a filling was performed on the same tooth within the previous 12 months, the benefit for the inlay will be reduced by the amount of the benefit paid for the filling.

**See Also:**

*Pretreatment Notification*, page 19.

**Lost or Stolen Appliances**

**Not Covered:** Including related services or supplies.

**Medical Services or Supplies**

**Not Covered:** Services or supplies that are medical in nature, including, but not limited to, dental services performed in a hospital and treatment of fractures or dislocations, cysts, malignancies, temporomandibular joint disorder, or accidental injuries.

**Nondental Services**

**Not Covered:** Including, but not limited to, charges related to: telephone consultations, failure to keep scheduled appointments, completion of a form, or dental information.

**Occlusal Adjustment**

**Covered:**

**Limited Occlusal Adjustment** including, but not limited to, reshaping the biting surfaces of one or more teeth.

**Not Covered:**

**Complete Occlusal Adjustment** which is a more complex procedure that requires several appointments and is intended to revise or alter the functional relationship between upper and lower teeth.

**Onlays**

**Covered:** Restoring tooth structure lost due to decay or fracture by replacing one or

more missing or damaged biting cusps of a tooth with an indirect fabrication when the tooth cannot be restored with a silver (amalgam) or tooth-colored (composite) filling.

**Service Maximum:**

- Onlays are a benefit once every five years per tooth beginning from the date the indirect fabrication is cemented in place.
- If a filling was performed on the same tooth within the previous 12 months, the benefit for the onlay will be reduced by the amount of the benefit paid for the filling.

**See Also:**

*Pretreatment Notification*, page 19.

**Oral Evaluations**

**Covered:** Preventive check-ups and problem-focused evaluations (i.e., dental examinations related to a particular injury or disease).

**Service Maximum:**

- Twice per benefit year.

**Oral Surgery (Routine)**

**Covered:** Including, but not limited to, pre- and post-operative care and local anesthetic for routine oral surgical services such as:

- Biopsy of hard and soft tissue.
- Removal of teeth, including impacted teeth.

**Periodontal Appliances**

**Not Covered:** Including, but not limited to, bite guards to reduce bite (occlusal) trauma due to tooth grinding or jaw clenching.

**Periodontal Procedures**

**Covered:**

**Conservative (Root Planing and Scaling).** Removing contaminants such

as bacterial plaque and tartar (calculus) from a tooth root to prevent or treat disease of the gum tissues and bone that support it.

**Complex.** Various surgical interventions designed to repair and regenerate gum and bone tissues that support the teeth.

**Periodontal Maintenance Therapy.**

Including, but not limited to, a periodic oral examination, pocket depth measurement, dental cleaning (oral prophylaxis), removal of stain, and scaling and polishing.

Periodontal maintenance therapy must follow conservative or complex periodontal therapy.

**Service Maximum:**

- Conservative periodontal procedures are a benefit only once every 24 months for each quadrant.
- Complex periodontal procedures are a benefit only once every three years for each quadrant of the mouth.
- During the 24-month period following initial conservative or complex periodontal therapy, maintenance benefits are available up to four times per benefit year. Each regular dental cleaning (prophylaxis) reduces the number of periodontal maintenance treatments that are covered.

**See Also:**

*Pretreatment Notification*, page 19.

**Posts and Cores**

**Covered:** Preparing a tooth for an indirect fabrication after a root canal when performed to restore tooth structure lost due to decay or fracture.

**Service Maximum:**

- Posts and cores are a benefit once every five years per tooth beginning from the date the indirect fabrication is cemented in place.

**See Also:**

*Pretreatment Notification*, page 19.

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## **Pulp Caps**

**Covered:**

**Direct.** Covering exposed pulp with a dressing or cement to protect it and promote healing and repair.

**Service Maximum:**

- Direct pulp caps are a benefit only once in a lifetime per tooth.

**Not Covered:**

**Indirect.** Treatment of pulp that is not exposed.

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## **Pulpotomy**

**Covered:** Removing the coronal portion of the pulp as part of root canal therapy. When performed on a baby (primary) tooth, pulpotomy is the only procedure required for root canal therapy.

**Not Covered:** When performed on a permanent tooth. In this case, pulpotomy is the first stage of root canal therapy and not covered as a separate procedure.

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## **Retrograde Fillings**

**Covered:** Sealing the root canal by preparing and filling it from the root end of the tooth.

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## **Root Canals**

**Covered:** Treating an infected or injured pulp to retain tooth function. This procedure generally involves removal of the pulp and replacement with an inert filling material.

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## **Sealant Applications**

**Covered:** Including, but not limited to, filling decay-prone areas of the chewing surface of molars.

**Service Maximum:**

- For eligible dependent children under age 15.

- Once in a lifetime per permanent first and second molars.

**Not Covered:** Sealants for primary teeth, wisdom teeth, or teeth that have already been treated with a restoration.

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## **Space Maintainers**

**Covered:** For missing back teeth.

**Service Maximum:** An eligible benefit only:

- Once in a lifetime per quadrant.
- For eligible dependent children under age 15.

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## **Veneers**

**Not Covered:** A layer of tooth-colored material typically made of composite, porcelain, ceramic or acrylic resin that is attached to the tooth surface by direct fusion, cementation, or mechanical retention. Veneers may also refer to a restoration that is sealed to the facial surface of a tooth.

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## **X-rays**

**Covered:**

**Bitewing X-rays.** X-rays that show the visible part of the teeth of both the upper and lower jaws and are used to detect cavities and periodontal disease.

**Full-Mouth X-rays.** X-rays that are a series of periapical and bitewing x-rays showing the teeth and underlying structures of the entire mouth.

**Occlusal and Extraoral X-rays.** Occlusal x-rays show the underlying structures of the teeth and are used to detect cysts and pathologies. These x-rays are taken from inside the mouth. Extraoral show the jaw and are used for orthodontic analysis or to detect fractures, jaw disorders, or other abnormalities. These x-rays are taken from outside the mouth.

**Periapical X-rays.** X-rays that show the tooth and underlying structures for one or more teeth.

**Service Maximum:**

- Bitewing x-rays once every 12 months.
- Full mouth x-rays once every five years.

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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

#### Dentally Necessary and Appropriate

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

Dentally necessary means the service meets both of the following standards:

- The diagnosis is proper.
- The service is dentally appropriate for the symptoms, diagnosis, and direct treatment necessary to preserve or restore the form and function of the tooth or teeth and the health of the gums, bone, and other tissues supporting the teeth.

Dentally appropriate means the service meets all of the following standards:

- The treatment is consistent with and meets professionally recognized standards of dental care and complies with criteria adopted by Wellmark in terms of type, frequency, setting, timing, duration, and is considered effective for your symptoms and diagnosis.

- The treatment is not provided primarily for your convenience or the convenience of your dentist.

An alternative dental procedure or supply may meet the criteria of being dentally appropriate. We reserve the right to approve the least costly alternative. If you receive alternative services other than the least costly, you are responsible for paying the difference.

#### 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 23.

#### General Exclusions

Even if a service, supply, or device 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, or device 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, or device 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 for consideration by all Blue Cross and Blue Shield member organizations. While we may rely on these criteria, the final decision remains at the discretion of our Medical Director, whose decision may include reference to, but is not controlled by, policies or decisions of other Blue Cross and Blue Shield member organizations. You may access our medical policies, with supporting information and selected medical references for a specific service, supply, or device through our Web site, [www.wellmark.com](http://www.wellmark.com).

### **Complications of a Noncovered Service**

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

### **Nondental Services**

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

### **Covered by Other Programs or Laws**

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

- You are entitled to claim benefits from a governmental program (other than Medicaid).
- Someone else has the legal obligation to pay for services and without this group health plan, you would not be charged.
- You require services or supplies for an illness or injury sustained while on active military status.

### **Workers' Compensation**

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

### **Benefit Limitations**

Benefit limitations refer to amounts for which you are responsible under this group health plan. In addition to the exclusions and conditions described earlier, the following are examples of benefit limitations under this group health plan:

- A service or supply that is not covered under this group health plan is your responsibility.
- If a covered service or supply reaches a service maximum, it is no longer eligible for benefits. (A maximum may renew at the next benefit year.) See *Details – Covered and Not Covered*, page 9.
- The type of provider you choose can affect your benefits and what you pay. See *Choosing a Provider*, page 17, and *Factors Affecting What You Pay*, page 21. 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 dentist.

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## 5. Choosing a Provider

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### Choosing a Dentist

This dental benefits plan is called Blue Dental. Dentists who participate with this plan and dentists outside the Blue Dental service area who participate with entities with whom Wellmark is affiliated are called participating dentists.

Dentists who do not participate with entities with whom Wellmark is affiliated are called nonparticipating dentists.

To determine if a dentist participates with this dental benefits plan, check the *Dental Provider Directory* on our Web site at [www.wellmark.com](http://www.wellmark.com) or call us. The Dental Provider Directory is also available, without charge, as a separate document.

Blue Dental allows you to receive covered services from almost any dentist you choose. However, you will usually pay less for services received from participating dentists. We recommend you:

- Go to a participating dentist whenever possible.
- Always present your ID card when receiving services.

### Advantages of Visiting Participating Dentists

- You will usually pay less for services. A nonparticipating dentist's charge for a service may be more than the amount we will cover. You are responsible for this difference.
- Claims are filed for you. If you visit a nonparticipating dentist, you are responsible for filing the claim.
- Participating dentists handle pretreatment notification for you.



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## 6. Pretreatment Notification

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### Pretreatment Notification of Dental Services

<b>Purpose</b>	Pretreatment notification is recommended to help us determine whether certain planned dental procedures are covered benefits. A pretreatment plan describes your dentist's recommended procedure and its estimated cost.
<b>Applies to</b>	Gum and Bone Diseases High Cost Restorations Bridges Dental Implants
<b>Person Responsible</b>	Participating dentists submit a treatment plan for you. You need to submit a treatment plan for yourself only if your dentist is nonparticipating.
<b>Process</b>	<p>Wellmark will review the treatment plan; however, the lack of a pretreatment estimate will not affect your benefits. If a service is dentally necessary and appropriate and is a benefit of your Blue Dental benefits plan, it will be covered according to the terms and limitations described in this summary plan description.</p> <p>A complete pretreatment estimate includes the plan of treatment, x-rays, diagnostic charts, and other documentation when applicable. Send the pretreatment plan with x-rays and supporting information to:</p> <p style="padding-left: 40px;">Wellmark Blue Cross and Blue Shield of Iowa P.O. Box 9354 Des Moines, IA 50306-9354</p> <p>Once we receive the treatment plan, we will inform you and your dentist within 15 working days whether the services are covered. We will either accept the treatment plan as submitted or deny it because procedures are not a benefit.</p>

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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.

### Benefit Year

A benefit year is the same as a calendar year. It begins on the effective date of the agreement between Wellmark Blue Cross and Blue Shield of Iowa and your employer or group sponsor and starts over each January 1. Your benefit year continues even if:

- Your employer or group sponsor changes Wellmark group health plan benefits during the year.
- A dependent child is removed from family coverage because of completion of schooling.
- A member is removed from coverage and enrolls in COBRA.

If you change coverage and your Wellmark identification number is changed, a new benefit year will start under the new ID number for the rest of the calendar year. In this case, the benefit year would be less than a full year.

The benefit year is important for calculating:

- Deductible.
- Service maximum.

### Participating vs. Nonparticipating Dentists

Wellmark sends claim payments directly to participating dentists. Wellmark does not send payments directly to nonparticipating dentists. If you receive services from a nonparticipating dentist, Wellmark will send payment to you, and you are responsible for ensuring that the dentist is paid in full. We do not have contracts with nonparticipating dentists, and they do not agree to accept our payment arrangements. If you visit a nonparticipating dentist, you

will be responsible for any difference between the nonparticipating dentist's amount charged and the maximum allowable fee.

### Amount Charged and Maximum Allowable Fee

#### Amount Charged

The amount charged is the amount a dentist charges for a service or supply, regardless of whether it is covered under this dental benefits plan.

#### Maximum Allowable Fee

The maximum allowable fee is the amount we establish, using various methodologies, for covered services and supplies. Our amount paid may be based on the lesser of the amount charged for a covered service or supply or the maximum allowable fee.

Information regarding the calculation and determination of the maximum allowable fee is available to you. Upon receiving your request for such information, Wellmark Blue Cross and Blue Shield of Iowa or your employer or group sponsor will provide the following:

- The frequency of the determination of the maximum allowable fee.
- A general description of the methodology used to determine the maximum allowable fee, including geographic locations.
- The percentile that determines the maximum benefit that we will pay for any dental procedure, if the maximum allowable fee is determined by taking a sample of fees submitted on actual claims from licensed dentists and then determining the benefit by selecting a percentile of those fees.

The maximum allowable fee may be less than the amount charged for the service or supply. You are responsible for this difference if you receive covered services from a nonparticipating dentist.

### **Payment Arrangements**

Wellmark has contracting relationships with participating dentists. To make services available on a similar basis outside Iowa, we have arrangements with entities affiliated with Wellmark who have their own dental networks. These contracts with dentists include payment arrangements that are made possible by our broad base of customers. We use different methods to determine payment arrangements. These payment arrangements usually result in savings.

In addition, these payment arrangements can affect how your coinsurance is calculated.

## 8. Coverage Eligibility and Effective Date

### Eligible Members

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

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

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

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

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

- Under age 19.
- A full-time student enrolled in an accredited educational institution. Full-time student status continues during:
  - Regularly-scheduled school vacations; and
  - Medically necessary leaves of absence until the earlier of one year from the first day of leave or the date coverage would otherwise end.
- 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. In addition, the child must have had qualifying dental coverage without a break of 63 days or more since turning age 19 or since becoming a full-time student. Qualifying dental coverage means dental coverage with a comparable scope of benefits as the coverage under this Blue Dental benefits plan.

### Enrollment Requirements

Each eligible employee who began work before the effective date of this coverage is eligible to enroll for this coverage on the effective date. New, eligible employees may enroll for coverage after 90 calendar days following the date of employment (subject to any new employment probationary period your group may have). The application must be received by us no later than 31 days following eligibility.

**Please note:** In addition to the preceding requirements, eligibility is affected by coverage enrollment events and coverage termination events. See *Coverage Change Events*, page 27.

### Eligibility Requirements

The following are eligibility requirements for participating in this health benefits plan.

**Full-time Employees.** A full-time employee means an employee who works a minimum of 40 hours per week. If you are a full-time employee, you are eligible to apply for coverage on your effective date as a full-time employee. See your employer or group sponsor for details.

### When Coverage Begins

Coverage begins on the member's effective date. If you have just started a new job, or if a coverage enrollment event allows you to add a new member, ask your employer or group sponsor about your effective date.

Services received before the effective date of coverage are not eligible for benefits.

## **Qualified Medical Child Support Order**

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

A QMCSO specifies information such as:

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

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

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

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

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

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

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

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

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

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

## **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.



## 9. Coverage Changes and Termination

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

### Coverage Change Events

**Coverage Enrollment Events:** The following events allow you as well as an affected spouse or eligible child to enroll for coverage.

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

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

- Dependent child resumes status as a full-time student.
- Addition of a natural child by court order. See *Qualified Medical Child Support Order*, page 24.
- Appointment as a child's legal guardian.
- Placement of a foster child in your home by an approved agency.

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

- Death.
- Divorce or annulment. Legal separation, also, may result in removal from

coverage. If you become legally separated, notify your employer or group sponsor.

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

### Requirement to Notify Group Sponsor

You must notify your employer or group sponsor within 31 days of most events that change the coverage status of members and within 60 days of events related to Medicaid or CHIP eligibility. 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 employer or group sponsor discontinues or replaces this group health plan.
- We terminate coverage of all similar group health plans by written notice to your employer or group sponsor 90 days prior to termination.

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

When you become unemployed and your eligibility is based on employment, your coverage will end on the last day of employment. When your coverage terminates for all other reasons, check with your employer or group sponsor or call the Customer Service number on your ID card to verify the coverage termination date.

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

Your coverage will terminate immediately if:

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

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

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

## Coverage Continuation

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

### **COBRA Continuation**

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 employer or group 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 employer or group sponsor during your period of employment with your employer or group 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 employer or group 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 employer or group sponsor of any of these three qualifying events.

For the other qualifying events, a COBRA election will be available only if you notify your employer or group 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 employer or group 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 Wellmark Blue Cross and Blue Shield of Iowa. 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 employer or group 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:

Wellmark Blue Cross and Blue Shield of  
Iowa  
636 Grand Avenue, Station 55  
Des Moines, IA 50309-2565

**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 Wellmark Blue Cross and Blue Shield of Iowa 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 Wellmark Blue Cross and Blue Shield of Iowa 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 employer or group 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 employer or group 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 employer or group 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 employer or group 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 employer or group 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 employer or group 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 employer or group 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 employer or group sponsor will require repayment of all benefits paid after the termination date, regardless of whether or when you provide notice to your employer or group 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 employer or group

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 employer or group sponsor will require repayment of all benefits paid after the termination date, regardless of whether or when you provide notice to your employer or group 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 Wellmark Blue Cross and Blue Shield of Iowa and mailed to:

Wellmark Blue Cross and Blue Shield of Iowa  
636 Grand Avenue, Station 55  
Des Moines, IA 50309-2565

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 Wellmark Blue Cross and Blue Shield of Iowa 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 employer or group 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 employer or group sponsor, the plan administrator. You may obtain information about COBRA coverage on request from:

Wellmark Blue Cross and Blue Shield of Iowa  
636 Grand Avenue, Station 55  
Des Moines, IA 50309-2565

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 employer or group sponsor).



# 10. Claims

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

## When to File a Claim

You need to file a claim if you:

- Use a provider who does not file claims for you. Participating dentists file claims for you.

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

For services received under the Blue Dental benefits plan, we send claim payments after a procedure is completed. Do not file a claim until after your treatment plan is completely finished.

## 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.

**Dental Claim Form.** Follow these steps to complete a dental 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.
  - Description of each dental service (eg., tooth number, letter, range, surface, and ADA procedure codes).

### 3. Sign the Claim Form

In addition to your signature, your dentist's signature is also required for dental claims.

### 4. Submit the Claim

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

Wellmark Blue Cross and Blue Shield of  
Iowa  
P.O. Box 9354  
Des Moines, IA 50306-9354

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 41.

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# 11. Coordination of Benefits

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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 dentist will forward your coverage information to us. If you have a nonparticipating dentist, 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.
- Benefits for dental services under your medical benefits plan are payable before benefits under your Blue Dental benefits plan.
- 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**

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.



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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.

## 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 49.

You must make your request for a review, in writing, within 180 days from the date you are notified of our adverse decision.

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

- Date of your request.
- Your name (please type or print), address, and if applicable, the name and address of your authorized representative.
- Member identification number.
- Claim number from your Explanation of Benefits, if applicable.
- Date of service in question.

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

## Where to Send Appeal

Wellmark Blue Cross and Blue Shield of Iowa  
ERISA Review Office  
P.O. Box 9354  
Des Moines, IA 50306-9354

## 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.

Appeals will be decided within 60 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 29.

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

You should be provided a certificate of qualifying dental 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 qualifying dental 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.

## **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*.

# 14. General Provisions

## Contract

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

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

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

## Interpreting this 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 employer or group sponsor has the authority to terminate, amend, or modify the coverage described in this summary

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

## Authorized Group 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 employer or group sponsor.
- Our receipt of proper notification that an event has changed your spouse or dependent's eligibility for coverage. See *Coverage Changes and Termination*, page 27.

## 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.

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

## Release of Information

You have agreed in your application (or in documents kept by us or your employer or

group sponsor) to release any necessary information requested about you so we can process claims for benefits.

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

### **Privacy of Information**

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

### **Treatment**

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

### **Payment**

We may use and disclose your health information to pay for covered services from physicians, hospitals, and other providers, to determine your eligibility for benefits, to coordinate benefits, to determine medical necessity, to obtain payment from your employer or group sponsor, to issue explanations of benefits to the person enrolled in the group health plan in which you participate, and the like. We may disclose your health information to a health care provider or entity subject to the federal privacy rules so they can obtain payment or engage in these payment activities.

### **Health Care Operations**

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

### **Other Disclosures**

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

### **Member Health Support Services**

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

- Use your personal health information (including, but not limited to, substance abuse, mental health, and HIV/AIDS information); and
- Disclose such information to your health care providers and Wellmark's health support service vendors, for purposes of providing such services to you.

Wellmark will use and disclose information according to the terms of our Privacy

Practices Notice, which is available upon request or at [www.wellmark.com](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 employer or group sponsor, will be subrogated to you and your legal representative's rights to recover from the third party as a condition to your receipt of benefits.

### **Right of Reimbursement**

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

amount paid by this group health plan on the claim.

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

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

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

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

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

- The name, address, and telephone number of the third party that in any

way caused the injury, and of the attorney representing the third party;

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

Send this information to:

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

You also agree to all of the following:

- You will immediately let us know about any potential claims or rights of recovery related to the illness or injury.
- You will furnish any information and assistance that we determine we will need to enforce our rights under this group health plan.
- You will do nothing to prejudice our rights and interests including, but not

limited to, signing any release or waiver (or otherwise releasing) our rights, without obtaining our written permission.

- You will not compromise, settle, surrender, or release any claim or right of recovery described above, without obtaining our written permission.
- If payment is received from the other party or parties, you must reimburse us to the extent of benefit payments made under this group health plan.
- In the event you or your attorney receive any funds in compensation for your illness or injury, you or your attorney will hold those funds (up to and including the amount of benefits paid under this group health plan in connection with the illness or injury) in trust for the benefit of this group health plan as trustee(s) for us until the extent of our right to reimbursement or subrogation has been resolved.
- The amount of our subrogation interest shall be paid first from any funds recovered on your behalf from any source, without regard to whether you have been made whole or fully compensated for your losses, and the “make whole” rule is specifically rejected and inapplicable under this group health plan.
- We will not be liable for payment of any share of attorneys’ fees or other expenses incurred in obtaining any recovery, except as expressly agreed in writing, and the “common fund” rule is specifically rejected and inapplicable under this group health plan.

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

reasonable attorney fees and costs, incurred for such recovery.

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

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

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

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

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

### **Workers’ Compensation**

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

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

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

### **Payment in Error**

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

### **Notice**

If a specific address has not been provided elsewhere in this 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.

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# Glossary

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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.

**Amount Charged.** The amount that a provider bills for a service or supply, whether or not it is covered under this group health plan.

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

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

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

**Member.** A person covered under this group health plan.

**Nonparticipating Dentist.** A dentist who does not participate with this dental benefits plan or with an entity outside the Blue Dental service area with whom Wellmark is affiliated.

**Participating Dentist.** A dentist who participates with this dental benefits plan, or a dentist outside the Blue Dental service area who participates with an entity with whom Wellmark is affiliated.

**Plan.** The group health benefits program offered to you as an eligible employee for purposes of ERISA.

**Plan Administrator.** The employer or group sponsor of this group health plan for purposes of the Employee Retirement Income Security Act.

**Plan Member.** The person who signed for this group health plan.

**Qualifying Dental Coverage.** Dental coverage with a comparable scope of benefits as the coverage under this dental benefits plan.

**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 dental condition.

**Spouse.** A husband or wife of the opposite sex as the result of a legal marriage, including an opposite-sex spouse under Iowa common law.

**We, Our, Us.** Wellmark Blue Cross and Blue Shield of Iowa.

**You, Your.** The plan member and family members eligible for coverage under this group health plan.



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