

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

Dallas County Group Health Plan



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Blue DentalSM

Dallas County

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

Important Information

This summary plan description describes your rights and responsibilities under your group health plan. For purposes of this dental summary plan description, the term group health plan represents your dental benefits 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, and considerations of eligibility (the *Coverage Eligibility and Effective Date* section).

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

Read Thoroughly

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

Your coverage includes many services, treatments, supplies, devices, and drugs. Throughout the summary plan description, the words *services or supplies* refer to any services, treatments,

supplies, devices, or drugs, as applicable in the context, that may be used to diagnose or treat a condition.

Plan Description

Plan Name:	Dallas County Group Health Plan
Plan Sponsor:	Dallas County
Employer ID Number:	42-6004172
When Plan Year Ends:	June 30
Participants of Plan:	Eligible Employees of Dallas County See <i>Coverage Eligibility and Effective Date</i> later in this summary plan description.
Plan Administrator and Agent for Service of Legal Process:	Board of Supervisors 902 Court Street Adel, IA 50003 Phone Number: 515-993-5806 Service of legal process may be made upon the plan administrator and/or agent.
How Plan Costs Are Funded:	The Plan Sponsor and the employees pay the costs of this Plan.
Type of Plan:	Group Health Plan
Type of Administration:	Self-Funded
Benefits Administered by:	Wellmark Blue Cross and Blue Shield of Iowa 1331 Grand Avenue Des Moines, IA 50309-2901

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
All Services	\$25 per person \$75 per family*		\$1,500	
Oral Evaluations	waived	0%		
Preventive Evaluations (check-ups)				
Problem-Focused Evaluations				
Dental Cleaning				
Fluoride Applications				
X-rays				
Periodontal Maintenance				
Therapy				
Sealant Applications				
Space Maintainers				
Cavity Repair		20%		
Contour of Bone				
Emergency Treatment				
General Anesthesia				
Limited Occlusal Adjustment				
Routine Oral Surgery				
Root Canals and Other Endodontic Services		20%		
Apicoectomy				
Direct Pulp Cap				
Pulpotomy				
Retrograde Fillings				
Root Canal Therapy				
Treatment of Gum and Bone Diseases		20%		
Conservative Procedures				
Complex Procedures				
High Cost Restorations		20%		
Crowns				
Inlays				
Onlays				
Posts and Cores				

Category	Deductible	Coinsurance	Benefit Year Maximum	Lifetime Maximum
Dentures and Bridges (Prosthetics) Bridges Dentures		50%		
Orthodontics	waived	50%	waived	\$1,000

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

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

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

Category	Covered	Not Covered	See Page	Benefits Maximums
Cavity Repair	●		10	
Cleaning (Prophylaxis)	●		10	Once every six months. Regular dental cleanings (prophylaxis) reduce the number of periodontal maintenance treatments that are covered.
Congenital Deformity		⊙	10	
Cosmetic Dental Procedures		⊙	10	
Crowns	●		10	Once every five years per tooth.
Dentures	●		10	Once every three years.
Drugs		⊙	10	
Emergency Treatment (Palliative)	●		11	
Fluoride Applications (Topical)	●		11	Once every six months.
Implants		⊙	11	
Infection Control, if an additional fee		⊙	11	
Inlays	●		11	Once every five years per tooth.
Localized Delivery of Antimicrobial Agents		⊙	11	
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	Once every six months.
Oral Surgery – Routine	●		12	
Periodontal Appliances		⊙	12	
Periodontal Procedures			12	
Conservative (Root Planing and Scaling)	●		12	
Complex	●		12	
Periodontal Maintenance Therapy	●		12	Periodontal maintenance benefits are available up to four times per benefit year. Each periodontal maintenance treatment reduces the number of regular dental cleanings (prophylaxis) that are covered.

Category	Covered	Not Covered	See Page	Benefits Maximums
Posts and Cores	●		12	Once every five years per tooth.
Pulp Caps			12	
Direct	●		12	Once in a lifetime per tooth.
Indirect		⊙	12	
Pulpotomy	●		13	
Retrograde Fillings	●		13	
Root Canals	●		13	
Sealant Applications	●		13	For eligible children under age 19.
Space Maintainers	●		13	For eligible children under age 15. Once in a lifetime.
Veneers		⊙	13	
X-rays			13	
Bitewing	●		13	Once every 12 months.
Full-Mouth	●		13	Once every 36 months.
Occlusal and Extraoral	●		13	
Periapical	●		13	

3. Details - Covered and Not Covered

All covered services or supplies listed in this section are subject to the general contract provisions and limitations described in this 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.

Alveoloplasty (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.

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.

Apicoectomy/Periradicular Surgery

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

See Also:

Exclusion Period, page 22.

Braces (Orthodontics)

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

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

Please note: Benefit payments are made in equal amounts:

- when treatment begins, and
- at six-month intervals until treatment is completed or until lifetime maximum benefits are exhausted.

You must have continuous eligibility under this dental benefits plan in order to receive ongoing orthodontic benefit payments. Before treatment begins, your dentist should submit a pretreatment estimate. An Estimate of Benefits form will be sent to you and your dentist indicating Wellmark's maximum allowable fee, including any deductible and coinsurance amounts you may owe. The pretreatment estimate serves as a claim form when treatment begins.

Benefits Maximum:

- Covered only for eligible 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.

Exclusion Period, page 22.

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.

Benefits Maximum:

- Bridges are a benefit once every three 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:

Exclusion Period, page 22.

Cavity Repair

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

Pre-formed resin crowns performed on a posterior tooth will be alternated to a stainless steel crown.

Tooth colored (composite) fillings performed on a posterior tooth will be alternated to an amalgam (silver) filling.

Not Covered:

- The cost difference between a tooth-colored (composite) filling and a silver (amalgam) filling if the restoration is for a back (posterior) tooth.
- The cost difference between a resin crown and a stainless steel crown if the restoration is for a back (posterior) tooth.

Cleaning (Prophylaxis)

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

Benefits Maximum:

- Once every six months. Regular dental cleanings (prophylaxis) reduce the number of periodontal maintenance treatments that are covered.

Congenital Deformity

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

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.

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.

Benefits 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:

Exclusion Period, page 22.

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.

Benefits Maximum:

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

See Also:

Exclusion Period, page 22.

Drugs

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

Emergency Treatment (Palliative)

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

Fluoride Applications (Topical)

Covered.

Benefits Maximum:

- Once every six months.

Implants

Not Covered: Replacing a missing permanent tooth with a surgically implanted dental prosthesis that is not removable by the patient.

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.

Benefits 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:

Exclusion Period, page 22.

Localized Delivery of Antimicrobial Agents

Not Covered.

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. You are also not covered for services delivered to you by a practitioner via real-time, interactive audio only, audio-visual technology, or web-based mobile device or similar electronic-based communication network.

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.

Benefits 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:

Exclusion Period, page 22.

Oral Evaluations

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

Benefits Maximum:

- Once every six months.

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.

Benefits Maximum:

- Periodontal maintenance benefits are available up to four times per benefit year. Each periodontal maintenance treatment reduces the number of regular dental cleanings (prophylaxis) that are covered.

See Also:

Exclusion Period, page 22.

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.

Benefits 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:

Exclusion Period, page 22.

Pulp Caps

Covered:

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

Benefits Maximum:

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

Not Covered:

Indirect. Treatment of pulp that is not exposed.

See Also:

Exclusion Period, page 22.

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.

See Also:

Exclusion Period, page 22.

Retrograde Fillings

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

See Also:

Exclusion Period, page 22.

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.

See Also:

Exclusion Period, page 22.

Sealant Applications

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

Benefits Maximum:

- For eligible children under age 19.

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

Space Maintainers

Covered: For missing back teeth.

Benefits Maximum: An eligible benefit only:

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

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.

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.

Benefits Maximum:

- Bitewing x-rays once every 12 months.
- Full mouth x-rays once every 36 months.

4. General Conditions of Coverage, Exclusions, and Limitations

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

Conditions of Coverage

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. Unless otherwise required by law, 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 21.

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.

Nondental Services

You are not covered for services including, but not limited to: telephone consultations, charges for failure to keep scheduled appointments, charges for completion of any form, or charges for dental information. You are also not covered for services delivered to you by a practitioner via real-time, interactive audio only, audio-visual technology, or web-based mobile device or similar electronic-based communication network.

Covered by Other Programs or Laws

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

- Someone else has the legal obligation to pay for services, has an agreement with you to not submit claims for services or,

without this group health plan, you would not be charged.

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

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 benefits maximum, it is no longer eligible for benefits. (A maximum may renew at the next benefit year.) See *Details – Covered and Not Covered*, page 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 19. An example of a charge that depends on the type of provider includes, but is not limited to:
 - Any difference between the provider's amount charged and our amount paid is your responsibility if you receive services from a nonparticipating dentist.

5. Choosing a Provider

Choosing a Dentist

Your dental benefits are called Blue Dental. Dentists who participate with the network utilized by these dental benefits 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 your dental benefits, ask your dentist, refer to our online *Blue Dental Provider Directory* at *Wellmark.com* or call the Customer Service number on your ID card.

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.

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

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

The benefit year is important for calculating:

- Deductible.
- Benefits 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 your dental benefits.

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.

7. Coverage Eligibility and Effective Date

Eligible Members

You are eligible for coverage if you meet your employer's or group sponsor's eligibility requirements. Your spouse may also be eligible for coverage if spouses are covered under this plan.

If a child is eligible for coverage under the employer's or group sponsor's eligibility requirements, the child must have one of the following relationships to the plan member or an enrolled spouse:

- A biological 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 biological child a court orders to be covered.

A 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 child must be one of the following:

- Under age 26.
- An unmarried 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.
- An unmarried child who is deemed disabled. The disability must have

existed before the child turned age 26 or while the child was a full-time student.

Wellmark considers a dependent disabled when he or she meets the following criteria:

- Claimed as a dependent on the employee's, plan member's, subscriber's, policyholder's, or retiree's tax return; and
- Enrolled in and receiving Medicare benefits due to disability; or
- Enrolled in and receiving Social Security benefits due to disability.

Documentation will be required.

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 on the first of the month following 30 days 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 25.

Eligibility Requirements

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

Full-time Employees. As defined by the employee handbook or collective bargaining agreement, elected officials, and individuals otherwise eligible according to the minimum standards of the Affordable Care Act. See your employer or group sponsor for details.

Retirees. You and your spouse are eligible to continue participating under this health benefits plan until age 65 if:

- You are age 55, and
- You meet the definition of retiree under the Iowa Public Employees Retirement System (IPERS), and
- You and your spouse are covered under this plan at the time you retire with this employer or group sponsor.

When Coverage Begins

Coverage begins on the member's effective date, subject to any exclusion period described below. 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.

Late Enrollees

A late enrollee is a member who declines coverage when initially eligible to enroll and then later wishes to enroll for coverage. However, a member is not a late enrollee if a qualifying enrollment event allows enrollment as a special enrollee, even if the enrollment event coincides with a late enrollment opportunity. See *Coverage Change Events*, page 25.

A late enrollee may enroll for coverage at the group's next renewal or enrollment period.

Exclusion Period

You must be covered by this Blue Dental benefits plan for 12 months before benefits are available in the following service categories:

- Root canals.
- Gum and bone diseases.
- High cost restorations.
- Dentures and bridges.
- Orthodontics (braces).

Exclusion periods apply when:

- You are a newly hired employee.
- Your employer or group sponsor initially offers dental coverage.

Changes to Information Related to You or to Your Benefits

Wellmark may, from time to time, permit changes to information relating to you or to your benefits. In such situations, Wellmark shall not be required to reprocess claims as a result of any such changes.

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 cannot 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 and will be allowed to enroll immediately. You or your spouse's employer or group sponsor will withhold any applicable share of the cost of the dependent's health care coverage from your compensation and forward this amount to us.

If you are subject to a waiting period that expires more than 90 days after we receive 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 the cost of coverage 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 covered employer to allow an employee with 12 months or more of service who has worked for 1,250 hours over the previous 12 months and who is employed at a worksite where 50 or more employees are employed by the employer within 75 miles of that worksite 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.

8. 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 or your eligible child to enroll for coverage. The following events may also allow your spouse to enroll for coverage if spouses are eligible for coverage under this plan.

- Birth, adoption, or placement for adoption by an approved agency.
- Marriage.
- Exhaustion of COBRA coverage.
- You or your eligible spouse or your dependent loses eligibility for qualifying dental coverage or his or her employer or group sponsor ceases contribution to qualifying dental coverage.
- Spouse (if eligible for coverage) 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 biological child by court order. See *Qualified Medical Child Support Order*, page 22.
- 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 (if spouses are eligible for coverage under this plan).

Legal separation, also, may result in removal from coverage. If you become legally separated, notify your employer or group sponsor.

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

- Completion of full-time schooling if the child is age 26 or older.
- Child who is not a full-time student or deemed disabled reaches age 26.
- Marriage of a child age 26 or older.

Reinstatement of Child

Reinstatement Events. A child up to age 26 who was removed from coverage may be reinstated on his or her parent's existing coverage under any of the following conditions:

- Involuntary loss of creditable coverage (including, but not limited to, group or *hawk-i* coverage).
- Loss of creditable coverage due to:
 - Termination of employment or eligibility.
 - Death of spouse.
 - Divorce.
- Court ordered coverage for spouse or minor children under the parent's health insurance.
- Exhaustion of COBRA or Iowa continuation coverage.
- The plan member is employed by an employer that offers multiple health plans and elects a different plan during an open enrollment period.
- A change in status in which the employee becomes eligible to enroll in this group health plan and requests enrollment. See *Coverage Enrollment Events* earlier in this section.

Reinstatement Requirements. A request for reinstated coverage for a child

up to age 26 must be made within 31 days of the reinstatement event. In addition, the following requirements must be met:

- The child must have been covered under the parent's current coverage at the time the child left that coverage to enroll in other creditable coverage.
- The parent's coverage must be currently in effect and continuously in effect during the time the child was enrolled in other creditable coverage.

Requirement to Notify Group Sponsor

You must notify your employer or group sponsor of an event that changes the coverage status of members. Notify your employer or group sponsor within 60 days in case of the following events:

- A birth, adoption, or placement for adoption.
- Divorce, legal separation, or annulment.
- Your dependent child loses eligibility for coverage.
- 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.

For all other events, you must notify your employer or group sponsor within 31 days of the event.

If you do not provide timely notification of an event that requires you to remove an affected family member, your coverage may be terminated.

If you do not provide timely notification of a coverage enrollment event, the affected person may not enroll until an annual group enrollment period.

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 decide to terminate or discontinue offering this plan by giving written notice to your employer or group sponsor.

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

When you become unemployed and your eligibility is based on employment, your coverage will end at the end of the month your employment ends. 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 or Intentional Misrepresentation of Material Facts

Your coverage will terminate immediately if:

- You use this group health plan fraudulently or intentionally misrepresent 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.

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

- We may declare this group health plan void retroactively from the effective date of coverage following a 30-day written notice. In this case, we will recover any claim payments made.
- Premiums may be retroactively adjusted as if the fraud or intentionally misrepresented material fact had been accurately disclosed in your application.
- We will retain legal rights, including the right to bring a civil action.

Nonpayment

If you or your employer or group sponsor fail to make required payments to us when due or within the allowed grace period, your coverage will terminate the last day of the month in which the required payments are due.

Coverage Continuation

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

COBRA Continuation

The federal Consolidated Omnibus Budget Reconciliation Act (COBRA) applies to most non-governmental employers with 20 or more employees. Generally, COBRA entitles you and eligible dependents to continue coverage if it is lost due to a qualifying event, such as employment termination, divorce, or loss of dependent status. You and your

eligible dependents will be required to pay for continuation coverage. Other federal or state laws similar to COBRA may apply if COBRA does not. Your employer or group sponsor is required to provide you with additional information on continuation coverage if a qualifying event occurs.

9. Claims

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

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

When to File a Claim

You need to file a claim if you:

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

Wellmark must receive claims within 180 days following the date of service of the claim or if you have other coverage that has primary responsibility for payment then within 180 days of the date of the other carrier's explanation of benefits.

For services received under your Blue Dental benefits, 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 *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

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

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

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

If you have other insurance coverage, our processing of your claim may utilize coordination of benefits guidelines. See *Coordination of Benefits*, page 31.

10. Coordination of Benefits

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

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

Other Coverage

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

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

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

- Hospital indemnity coverage or other fixed indemnity coverage.
- Accident-only coverage.
- Specified disease or specified accident coverage.
- Limited benefit health coverage, as defined by Iowa law.

- School accident-type coverage.
- Benefits for nonmedical components of long-term care policies.
- Medicare supplement policies.
- Medicaid policies.
- Coverage under other governmental plans, unless permitted by law.

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

Your participating dentist will forward your coverage information to us. If you see 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 within 180 days of the date of the other carrier's explanation of benefits. We may contact your provider or the other carrier for further information.

Rules of Coordination

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

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

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

- The coverage that you have as an employee, plan member, subscriber, policyholder, or retiree pays before coverage that you have as a spouse or dependent. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent and primary to the plan covering the person as other than a dependent (e.g., a retired employee), then the order of benefits between the two plans is reversed, so that the plan covering the person as the employee, plan member, subscriber, policyholder or retiree is the secondary plan and the other plan is the primary plan.
- The coverage that you have as the result of active employment (not laid off or retired) pays before coverage that you have as a laid-off or retired employee. The same would be true if a person is a

dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other plan does not have this rule and, as a result, the plans do not agree on the order of benefits, this rule is ignored.

- If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an employee, plan member, subscriber, policyholder or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the primary plan and the COBRA or state or other federal continuation coverage is the secondary plan. If the other plan does not have this rule and, as a result, the plans do not agree on the order of benefits, this rule is ignored.
- The coverage with the earliest continuous effective date pays first if none of the rules above apply.
- Benefits for dental services under your medical benefits plan are payable before benefits under your Blue Dental benefits 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.
- For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, as outlined previously in this *Dependent Children* section.

Effects on the Benefits of this Plan

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

If a person is enrolled in two or more closed panel plans and if, for any reason including the provision of service by a non-panel provider, benefits are not payable by one closed panel plan, coordination of benefits will not apply between that plan and other closed panel plans.

Right of Recovery

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

11. Appeals

Right of Appeal

You have the right to one full and fair review in the case of an adverse benefit determination that denies, reduces, or terminates benefits, or fails to provide payment in whole or in part. Adverse benefit determinations include a denied or reduced claim.

How to Request an Internal Appeal

You or your authorized representative, if you have designated one, may appeal an adverse benefit determination within 180 days from the date you are notified of our adverse benefit determination by submitting a written appeal. Appeal forms are available at our website, *Wellmark.com*. See *Authorized Representative*, page 41.

You must make your request for a review in writing.

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

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

If you have difficulty obtaining this information, ask your dentist to assist you.

Where to Send Internal Appeal

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

Review of Internal Appeal

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

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

Decision on Internal Appeal

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

Appeals will be decided within 60 days and you will be notified in writing of our decision.

Arbitration and Legal Action

You shall not start arbitration or legal action against us until you have exhausted the

appeal procedure described in this section. See the *Arbitration and Legal Action* section and *Governing Law*, page 43, for important information about your arbitration and legal action rights after you have exhausted the appeal procedures in this section.

12. Arbitration and Legal Action

PLEASE READ THIS SECTION CAREFULLY

Mandatory Arbitration

You shall not start an action against us on any Claims (as defined below) unless you have first exhausted the appeal processes described in the *Appeals* section of this summary plan description.

Except as solely discussed below, this section provides that Claims must be resolved by binding mandatory arbitration. Arbitration replaces the right to go to court, have a jury trial or initiate or participate in a class action. In arbitration, disputes are resolved by an arbitrator, not a judge or a jury. Arbitration procedures are simpler and more limited than in court.

Covered Claims

Except as solely stated below, you or we must arbitrate any claim, dispute or controversy arising out of or related to this summary plan description or any other document related to your health plan, including, but not limited to, member eligibility, benefits under your health plan or administration of your health plan (any and/or all of the foregoing called “Claims”).

Except as stated below, all Claims are subject to mandatory arbitration, no matter what legal theory they are based, whether in law or equity, upon or what remedy (damages, or injunctive or declaratory relief) they seek, including Claims based on contract, tort (including intentional tort), fraud, agency, your or our negligence, statutory or regulatory provisions, or any other sources of law; counterclaims, cross-claims, third-party claims, interpleaders or otherwise; Claims made regarding past, present or future conduct; and Claims made independently or with other claims. This also includes Claims made by or against anyone connected with us or you or claiming through us or you, or by someone

making a claim through us or you, such as a covered family member, employee, agent, representative, or an affiliated or subsidiary company. For purposes of this *Arbitration and Legal Action* section, the words “we,” “us,” and “our” refer to Wellmark, Inc. and its subsidiaries and affiliates, the plan sponsor and/or the plan administrator, as well as their respective directors, officers, employees and agents.

No Class Arbitrations and Class Actions Waiver

YOU UNDERSTAND AND AGREE THAT YOU AND WE BOTH ARE VOLUNTARILY AND IRREVOCABLY WAIVING THE RIGHT TO PURSUE OR HAVE A DISPUTE RESOLVED AS A PLAINTIFF OR CLASS MEMBER IN ANY PURPORTED CLASS, COLLECTIVE OR REPRESENTATIVE PROCEEDING PENDING BETWEEN YOU AND US. YOU ARE AGREEING TO GIVE UP THE ABILITY TO PARTICIPATE IN CLASS ARBITRATIONS, CLASS ACTIONS AND ANY OTHER COLLECTIVE OR REPRESENTATIVE ACTIONS. Neither you nor we consent to the incorporation of the AAA Supplementary Rules for Class Arbitration into the rules governing the arbitration of Claims. The arbitrator has no authority to arbitrate any claim on a class or representative basis and may award relief only on an individual basis. Claims of two or more persons may not be combined in the same arbitration, unless both you and we agree to do so.

Claims Excluded from Mandatory Arbitration

- Small Claims – individual Claims filed in a small claims court are not subject to arbitration, as long as the matter stays in small claims court.
- Claims Excluded By Applicable Law – federal or state law may exempt certain Claims from mandatory arbitration. **IF**

AN ARBITRATOR DETERMINES A PARTICULAR CLAIM IS EXCLUDED FROM ARBITRATION BY FEDERAL OR STATE LAW, CLAIMS EXCLUDED BY APPLICABLE LAW, LATER IN THIS SECTION, AND GOVERNING LAW, PAGE 43, WILL APPLY TO THE PARTIES AND SUCH PARTICULAR CLAIM.

Arbitration Process Generally

- No demand for arbitration of a Claim because of a health benefit claim under this plan, or because of the alleged breach of this plan, shall be made more than two years after the end of the calendar year in which the services or supplies were provided.
- Arbitration shall be conducted by the American Arbitration Association (“AAA”) according to the Federal Arbitration Act (“FAA”) (to the exclusion of any state laws inconsistent therewith), this arbitration provision and the applicable AAA Consumer Arbitration Rules in effect when the Claim is filed (“AAA Rules”), except where those rules conflict with this arbitration provision. You can obtain copies of the AAA Rules at the AAA’s website (www.adr.org). You or we may choose to have a hearing, appear at any hearing by phone or other electronic means, and/or be represented by counsel. Any in-person hearing will be held in the same city as the U.S. District Court closest to your billing address.
- Either you or we may apply to a court for emergency, temporary or preliminary injunctive relief or an order in aid of arbitration (i) prior to the appointment of an arbitrator or (ii) after the arbitrator makes a final award and closes the arbitration. Once an arbitrator has been appointed until the arbitration is closed, emergency, temporary or preliminary injunctive relief may only be granted by the arbitrator. Either you or we may apply to a court for enforcement of any emergency, temporary or preliminary injunctive relief granted by the arbitrator.
- Arbitration may be compelled at any time by either party, even where there is a pending lawsuit in court, unless a trial has begun or a final judgment has been entered. Neither you nor we waive the right to arbitrate by filing or serving a complaint, answer, counterclaim, motion, or discovery in a court lawsuit. To invoke arbitration, a party may file a motion to compel arbitration in a pending matter and/or commence arbitration by submitting the required AAA forms and requisite filing fees to the AAA.
- The arbitration shall be conducted by a single arbitrator in accordance with this arbitration provision and the AAA Rules, which may limit discovery. The arbitrator shall not apply any federal or state rules of civil procedure for discovery, but the arbitrator shall honor claims of privilege recognized at law and shall take reasonable steps to protect plan information and other confidential information of either party if requested to do so. The parties agree that the scope of discovery will be limited to non-privileged information that is relevant to the Claim, and consistent with the parties’ intent, the arbitrator shall ensure that allowed discovery is reasonable in scope, cost-effective and non-onerous to either party. The arbitrator shall apply the FAA and other applicable substantive law not inconsistent with the FAA, and may award damages or other relief under applicable law.
- The arbitrator shall make any award in writing and, if requested by you or us, may provide a brief written statement of the reasons for the award. An arbitration award shall decide the rights and obligations only of the parties named in the arbitration and shall not have any bearing on any other person or dispute.

IF ARBITRATION IS INVOKED BY ANY PARTY WITH RESPECT TO A CLAIM, NEITHER YOU NOR WE WILL HAVE THE RIGHT TO LITIGATE THAT CLAIM IN COURT OR HAVE A JURY TRIAL ON THAT CLAIM, OR TO ENGAGE IN PREARBITRATION DISCOVERY EXCEPT AS PROVIDED FOR IN THE APPLICABLE ARBITRATION RULES. THE ARBITRATOR'S DECISION WILL BE FINAL AND BINDING. YOU UNDERSTAND THAT OTHER RIGHTS THAT YOU WOULD HAVE IF YOU WENT TO COURT MAY ALSO NOT BE AVAILABLE IN ARBITRATION.

Arbitration Fees and Other Costs

The AAA Rules determine what costs you and we will pay to the AAA in connection with the arbitration process. In most instances, your responsibility for filing, administrative and arbitrator fees to pursue a Claim in arbitration will not exceed \$200. However, if the arbitrator decides that either the substance of your claim or the remedy you asked for is frivolous or brought for an improper purpose, the arbitrator will use the AAA Rules to determine whether you or we are responsible for the filing, administrative and arbitrator fees.

You may wish to consult with or be represented by an attorney during the arbitration process. Each party is responsible for its own attorney's fees and other expenses, such as witness fees and expert witness costs.

Confidentiality

The arbitration proceedings and arbitration award shall be maintained by the parties as strictly confidential, except as is otherwise required by court order, as is necessary to confirm, vacate or enforce the award, and for disclosure in confidence to the parties' respective attorneys and tax advisors of a party who is an individual.

Questions of Arbitrability

You and we mutually agree that the arbitrator, and not a court, will decide in the first instance all questions of substantive arbitrability, including without limitation the validity of this Section, whether you and we are bound by it, and whether this Section applies to a particular Claim.

Claims Excluded By Applicable Law

If an arbitrator determines a particular Claim is excluded from arbitration by federal or state law, you and we agree that the following terms will apply to any legal or equitable action brought in court because of such Claim:

- You shall not bring any legal or equitable action against us because of a health benefit claim under this 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.
- 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.
- **YOU AND WE BOTH WAIVE ANY RIGHT TO A JURY TRIAL WITH RESPECT TO AND IN ANY CLAIM.**
- **FURTHER, YOU AND WE BOTH WAIVE ANY RIGHT TO SEEK OR RECOVER PUNITIVE OR EXEMPLARY DAMAGES WITH RESPECT TO ANY CLAIM.**

Survival and Severability of Terms

This *Arbitration and Legal Action* section will survive termination of the plan. If any portion of this provision is deemed invalid or unenforceable under any law or statute it will not invalidate the remaining portions of this *Arbitration and Legal Action* section or the plan. To the extent a Claim qualifies for mandatory arbitration and there is a conflict or inconsistency between the AAA Rules

and this *Arbitration and Legal Action* section, this *Arbitration and Legal Action* section will govern.

13. 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, unless otherwise required by law, 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 Benefits Plan Changes

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

- Written amendment signed by an authorized officer and accepted by you or your employer or group sponsor.
- Our receipt of proper notification that an event has changed your spouse or dependent's eligibility for coverage. See *Coverage Changes and Termination*, page 25.

Authorized Representative

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

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

Release of Information

By enrolling in this group health plan, you have agreed to release any necessary

information requested about you so we can process claims for benefits.

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

Privacy of Information

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

Treatment

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

Payment

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

Health Care Operations

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

Other Disclosures

Your employer or group sponsor or Wellmark is required to obtain your explicit authorization for any use or disclosure of your health information that is not permitted or required by law. For example, we may release claim payment information to a friend or family member to act on your behalf during a hospitalization if you submit an authorization to release information to that person. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect.

Member Health Support Services

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

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

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

Wellmark will use and disclose information according to the terms of our Privacy Practices Notice, which is available upon request or at *Wellmark.com*.

Value Added or Innovative Benefits

Wellmark may, from time to time, make available to you certain value added or innovative benefits for a fee or for no fee. Examples include Blue365[®], identity theft protections, and discounts on alternative/preventive therapies, fitness, exercise and diet assistance, and elective procedures as well as resources to help you make more informed health decisions. Wellmark may also provide rewards or incentives under this plan if you participate in certain voluntary wellness activities or programs that encourage healthy behaviors. Your employer is responsible for any income and employment tax withholding, depositing and reporting obligations that may apply to the value of such rewards and incentives.

Nonassignment

Except as required by law, benefits for covered services under this group health plan are for your personal benefit and cannot be transferred or assigned to anyone else without our consent. Whether made before or after services are provided, you are prohibited from assigning any claim. You are further prohibited from assigning any cause of action arising out of or relating to this group health plan. Any attempt to assign this group health plan, even if assignment includes the provider's rights to receive payment, will be null and void. Nothing contained in this group health plan shall be construed to make the health plan or Wellmark liable to any third party to whom a member may be liable for medical care, treatment, or services.

Governing Law

To the extent not superseded by the laws of the United States, the group health plan will be construed in accordance with and governed by the laws of the state of Iowa.

Medicaid Enrollment and Payments to Medicaid

Assignment of Rights

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

Enrollment Without Regard to Medicaid

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

Acquisition by States of Rights of Third Parties

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

Medicaid Reimbursement

When a provider submits a claim to a state Medicaid program for a covered service and Wellmark reimburses the state Medicaid program for the service, Wellmark's total payment for the service will be limited to the amount paid to the state Medicaid program. No additional payments will be made to the provider or to you.

Payment in Error

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

If we determine we did not make full payment, Wellmark will make the correct payment without interest.

Notice

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

Wellmark Blue Cross and Blue Shield of
Iowa
1331 Grand Avenue
Des Moines, IA 50309-2901

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

Consent to Telephone Calls and Text or Email Notifications

By enrolling in this employer sponsored group health plan, and providing your phone number and email address to your employer or to Wellmark, you give express consent to Wellmark to contact you using the email address or residential or cellular telephone number provided via live or pre-recorded voice call, or text message notification or email notification. Wellmark may contact you for purposes of providing important information about your plan and benefits, or to offer additional products and services related to your Wellmark plan. You may revoke this consent by following instructions given to you in the email, text or call notifications, or by telling the Wellmark representative that you no longer want to receive calls.

Glossary

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

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 Health Plan. For purposes of this dental summary plan description, the term group health plan represents your dental benefits plan.

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 your dental benefits or with an entity outside the Blue Dental service area with whom Wellmark is affiliated.

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

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

Plan Year. A date used for purposes of determining compliance with federal legislation.

Qualifying Dental Coverage. Dental coverage with a comparable scope of benefits as the coverage under your dental benefits.

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 man or woman lawfully married to a covered member.

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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