FIVE RIVERS CARPENTERS DISTRICT COUNCIL HEALTH AND WELFARE FUND

SUMMARY PLAN DESCRIPTION

Effective January 1, 2017

Important Notice from the
Five Rivers Carpenters District Council Health and Welfare Fund

The Plan Administrator of the Five Rivers Carpenters District Council Health and Welfare Plan believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Third-Party Administrator at Eastern Iowa Fringe Benefit Funds, Inc., 1831 16th Avenue SW, Cedar Rapids, IA 52404, at 319-366-3623. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Five Rivers Carpenters District Council Health and Welfare Fund
c/o Eastern Iowa Fringe Benefit Funds, Inc.
1831 16th Avenue SW, Cedar Rapids, IA 52404
319-366-3623

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YOUR RESPONSIBILITIES AS A PARTICIPANT

There are certain responsibilities which you, as a Participant, must assume. Failure to carry out these responsibilities could affect your eligibility or the benefits payable.

1. Take time to read this Summary Plan Description.

2. File an Employee Data (Enrollment) Card. You will need to provide a marriage certificate for a spouse and a birth certificate for any eligible children you wish to have included in the plan.

3. Notify the Fund Office promptly in writing if you have:

    a. A change of address; or
    b. A change in marital status; or
    c. A change in beneficiary; or
    d. A change in Dependents; or
    e. Been called or are returning from Military Service, or
    f. Been planning on retiring and your choice for a Retiree Program (beginning on page 12)

4. Make self-payments on time and in the correct amount.

A detailed explanation of your responsibilities can be found in the appropriate section of this Plan. Please refer to the Table of Contents for page numbers.

If You Move, Notify The Plan Office Immediately

Most information about your plan is sent to you by mail. For you to receive this information, there must be a correct address on file at the Plan Office **at all times.**

If you move, it's **up to you** to let the Plan Office know your new address. Failure to do so may jeopardize your eligibility of benefits because the Plan Office has no way to contact you about any changes in the eligibility rules or improvements in benefits.

Remember: The responsibility for letting the Plan Office know your new address is yours.

Plan Office Address:

Eastern Iowa Fringe Benefit Funds, Inc.
Five Rivers Carpenters District Council Health and Welfare Fund
1831 – 16th Ave SW
Cedar Rapids, IA 52404

IMPORTANT PROOF OF LOSS REQUIREMENTS

For Short Term Disability Benefits (Weekly Loss of Time), written proof of loss of time on account of disability or of hospital confinement must be furnished to the Plan Office (the Third-Party Administrator) within ninety days after the determination of the period for which the claim is made. Written proof of any other loss on which the claim may be based must be furnished to the Plan Office not later than ninety days after the date of the loss. Failure to furnish notice or proof of claim within the time provided in the Plan will not invalidate or reduce any claim if it was not reasonably possible to give proof within that time and proof is furnished as soon as reasonably possible. In no event, except in the absence of legal capacity of the Employee, will the Fund accept a claim later than one year from the time proof is otherwise required.

Benefits payable under the Plan for any loss other than Weekly Accident and Sickness will be paid as they accrue immediately upon receipt of due written proof of loss. Subject to due written proof of loss, all accrued benefits for loss of time will be paid at the times set forth in the applicable benefit provision and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

Death Benefits will be payable in accordance with the beneficiary designation and the provisions respecting such payment which are prescribed herein and effective at the time of payment. If no such designation or provision is then effective, the benefit will be payable to the estate of the Employee. Any other accrued benefits unpaid at the Employee's death may, at the option of the Trustees, be paid either to the beneficiary or to the estate. All other benefits will be payable to the Employee.

Subject to any written direction of the Employee, all or a portion of any benefits provided by the Plan on account of hospital, nursing, medical or surgical service may, at the Trustees' option, and unless the Employee requests otherwise in writing no later than the time for filing proof of the loss, be paid directly to the hospital or person rendering the services, but it is not required that the service be rendered by a particular hospital or person.

GENERAL SUMMARY OF SCHEDULED BENEFITS

Members and Dependents

For detailed description, go to Pages 17 to 32.

DEATH AND ACCIDENTAL DEATH BENEFITS AND DISMEMBERMENT (AD & D) BENEFITS

Death Benefit (Member and Dependents)

All Causes	
Member	$ 10,000.00
Spouse	$ 4,000.00
Dependent Child(ren)	$ 4,000.00

Dependent Child(ren) means the Insured's unmarried children, including natural, or adopted children from the moment of placement in the home of the Insured, under age 26 and primarily dependent on the Insured for support and maintenance.

Accidental Death & Dismemberment (AD&D) Benefit

AD&D – Principal sum (Bargaining Agreement Members Only)	$35,000.00

SHORT TERM DISABILITY BENEFIT

Weekly Loss of Time (Bargaining Agreement Members Only)

Non-Occupational Benefits	
Payment Begins - for Injury	1st day
Payment Begins - for Sickness	8th day
Weekly Benefit	$300.00
Maximum Payment Period	26 Weeks

COMPREHENSIVE MAJOR MEDICAL BENEFITS — SEE PAGE 17 AND EXHIBIT A

PHARMACY BENEFIT

Reimbursement rate – up to 30 days' supply	
Prescription Type	
Generic	the greater of $10 or 10%
Brand Name Prescription	the greater of $20 or 20%

Reimbursement rate for Mail Order or Online Pharmacy 90-day Supply	
Prescription Type	
Generic	$0
Brand Name Prescription	the greater of $40 or 20%

Life Style Drugs	Not covered which may include the following, but are not limited to: Smoking cessation; impotence medication, fertility medications, hair loss agents, dermatological agents, or oral contraceptives.

Note: The prescription drug card co-payment does not apply to the medical plan's deductible or out-of-pocket maximum. Secondary co-pays are not covered and are not a Plan benefit.

DENTAL CARE BENEFITS

Deductible Amount	None
Maximum Benefit Payable	$300.00 per person per calendar year
Dependent Children Up to Age 18	
Deductible Amount	None
Maximum Benefit Payable	Limited to 2 exams per calendar year plus other Benefits listed on page 22.

VISION CARE BENEFITS

Deductible	None
Complete Eye Examination, Lenses for Glasses, Frames, Contact Lenses	
Maximum Benefit Payable	$200.00 per person each 2 calendar year period. Current period (1/1/16 – 12/31/17)
Dependent Children Up to Age 18	
Deductible	None
Complete Eye Examination and One Pair of Lenses For Glasses	
Maximum Benefit Payable	None

INTRODUCTION

This document is the Summary Plan Description of Five Rivers Carpenters District Council Health and Welfare Fund (the Plan). **No oral interpretations can change this Summary Plan Description or the Plan**. The Plan described is designed to protect Plan Participants against lost income during periods of disability or certain catastrophic health expenses.

Coverage under the Plan will take effect for an eligible Employee and designated Dependents when the Employee and such Dependents satisfy all the eligibility requirements of the Plan.

The Trustees fully intend to maintain this Plan as long as there are contributions to the Plan required by the Collective Bargaining Agreement between contributing Employers and the signatory Local Unions of the United Brotherhood of Carpenters and Joiners of America. However, the Trustees reserve the right to alter or amend the Plan **at any time and for any reason**.

The Board of Trustees establishes the eligibility rules, strives to maintain the Schedule of Benefits, supervise the investment of the Fund's money, and sees that the Fund is in compliance with all applicable Federal laws and regulations.

In carrying out these responsibilities, the Trustees are assisted by a team of professionals including:

1. The **Third-Party Administrator** who handles the day-to-day business activities of the Fund such as collecting employer contributions, keeping records of money received, crediting each participant's account with the correct contributions worked, paying dental, vision and HRA Account claims (not medical claims), and answering inquiries from participants about their eligibility and benefits.

2. The **Fund Attorney** advises the Trustees about what must be done to assure that all operations of the Fund comply with Federal and State laws.

3. The **Fund Consultant** assists the Trustees in determining the level of benefits which can be provided from Fund resources and advises the Trustees on other matters important to the Fund's operations.

4. The **Fund Actuary** reviews the claims of the trust quarterly and makes recommendations regarding contributions and benefit modifications to the Trustees while considering the Plan's claims reserves. The Fund actuary works closely with the Fund's benefit consultant and the Fund's legal counsel on these issues.

5. **Wellmark BlueCross and BlueShield of Iowa** administers the medical benefits for the Fund, including paying the medical claims and answering inquiries from participants about their medical benefits and providers.

Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, deductibles, maximums, co-payments, exclusions, limitations, definitions, eligibility and the like.

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as but not by way of limitation, coordination of benefits, subrogation, exclusions, timeliness of COBRA elections, utilization review or other cost management requirements, lack of Medical Necessity, lack of timely filing of claims or lack of coverage.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated. An expense for a service or supply is incurred on the date the service or supply is furnished.

If the Plan is terminated, amended, or benefits are eliminated, the rights of Covered Persons are limited to Covered Charges incurred before termination, amendment or elimination.

ELIGIBILITY, FUNDING, ENROLLMENT AND TERMINATION PROVISIONS

A Plan Participant should contact the Third-Party Administrator to obtain additional information, free of charge, about Plan coverage of a specific benefit, particular drug, treatment, test or any other aspect of Plan benefits or requirements. A Plan Participant should contact Wellmark Blue Cross and Blue Shield to obtain information on medical benefit coverage.

ELIGIBILITY

Bargaining Unit Employees

All Employees working for a contributing Employer pursuant to a Collective Bargaining Agreement with Local 4, 166, 678, 308, and 1260 of the Industrial Brotherhood of Carpenters (Local Union Contract) shall be eligible to receive benefits after meeting the following eligibility requirements.

Mid-Quarter

1. **Initial Eligibility for Participants Working Under a Collective Bargaining Agreement**

   Once a Participant has accumulated $3,030 in the sum of the DB and the HRA accounts within 12 consecutive months in covered employment under a Local Union Contract to which contributing employers are signatory, the Participant will gain initial eligibility into the Health & Welfare Plan. Benefit coverage will begin the first of the month following the month the $3,030 of contribution was **RECEIVED** at the Fund Office. The following is an example:

Month A	The Following Month B	The Following Month C
You meet your $3,030 dollar eligibility requirement…	The Contractor reports your contributions worked for prior Month A to THIRD-PARTY ADMINISTRATOR	The Third-Party Administrator then sends Notice of eligibility beginning the **FIRST OF THE MONTH C**

   So, for example, if you reached $3,030 in January, your coverage begins March 1st.

   The Employee's eligibility after the first quarter of eligibility will be determined under the provisions for Continuation of Eligibility. For initial eligibility, the Participant's accumulated DB and HRA accounts in the initial eligibility quarter will be charged at the rate of $1,010 per month for the number of months remaining in the initial quarter in which the Participant attained eligibility. For example, the Participant who attained their $3,030th work contribution in January would be eligible for benefits March 1st. March is the third month of the first coverage quarter (see coverage quarters following). Since only one month (March) remains in the coverage month quarter, the Participant's accumulated DB and HRA accounts would be deducted on the 1st of March in the amount of $1,010.

2. **Continuation of Eligibility**

   Once a Participant becomes eligible, he/she will continue to be covered under the Plan of Benefits for a coverage quarter. Eligibility will continue for subsequent coverage quarters, unless there is a terminating event, as long as the Participant has $3,030 of contribution credit in his/her accumulated DB and HRA accounts at the beginning of such period. A Coverage Quarter is defined according to the following schedule:

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

HOW YOUR DB AND HRA ACCOUNTS WORK

All contributions made on a member's behalf while working for a participating employer are made to the DB account. Once the DB account reaches the current required level of $150.00, all contributions made for the member on or after January 1, 2012, are transferred to their HRA. Note: no contributions can be transferred from a member's HRA to their personal DB account. Also, your accounts can never be negative. There is no maximum on your HRA account.

Eligibility reports will be sent to each member each quarter to inform them of the number of hours contributed on their behalf by the employer in the preceding twelve months. Should you notice any discrepancy in the reported hours,

contact the fund office. This report also provides you with a summary of the activity for your DB and HRA accounts for the last quarter.

If you have lost your eligibility, and wish to self-pay, you have until the last business day of the month preceding the beginning of the eligibility quarter for which you are making payment. Loss of eligibility will cause your accounts to be reduced to zero.

Your HRA account will be charged during each calendar year for all eligible reimbursements. The amount available for reimbursement for Allowable Medical Care Expenses is the balance available in your HRA, which are the contributions credited to your Individual Account less any reimbursements paid.

PARTICIPANT'S CONTRIBUTIONS

Contributions for hours worked will not be added to a Participant's DB account until the cash contribution for the hours worked is actually received by the Fund Office and added to the Participant's DB account for purposes of determining eligibility for Fund Benefits.

DELINQUENT CONTRACTOR CLARIFICATION

If a Contractor becomes delinquent more than three times in a running twelve-month period, then such Contractor must post a cash bond equal to the three highest months of contributions during the previous six-month period in order to continue participation in the Fund. Failure of the delinquent Contractor to post the cash bond within fifteen (15) days of Notice given by the Fund shall result in the Fund notifying the collective Bargaining Representative of the Contractor's employees that the Fund will not accept contributions from the contractor until the Bond is posted and the Contractor's employees eligibility accrual for Fund benefits could be in jeopardy.

CONTINUATION OF ELIGIBILITY WITHOUT EMPLOYER CONTRIBUTIONS

Participants will continue to be covered by the Plan of Benefits so long as a Participant has dollars accumulated in their DB and HRA accounts sufficient to continue their coverage. Participant's coverage shall be terminated at the end of the coverage quarter when the Participant's account is reduced to zero. Participant's accounts will be reduced to zero when:

1. The Participant stops working for contributing employers when such work is otherwise available; or,

2. A Participant is promoted by an employer to an employment category not covered by the Collective Bargaining Agreement in effect between the employer and the union at the time of such promotion (See "**Participants Promoted to Non-Bargaining Category for Contributing Employer**" below); or,

3. Participant's accounts are less than $3,030 at the beginning of an eligibility quarter, due to unemployment and Participant does not make up the difference in self-contribution for the quarter; or

4. A Participant goes to work for an Employer in the Carpentry industry who is not signatory to a Collective Bargaining Agreement with a Local Carpenters Union.

SELF-PAYMENT OF CONTRIBUTIONS

After a Participant becomes initially eligible, and the Participant has insufficient hours in his/her accumulated DB and HRA accounts at the beginning of a coverage quarter, the Participant may be allowed to make self-payments of contributions if the Participant is in danger of losing eligibility due to a period of unemployment.

To be eligible to make self-payments, the Participant must be available for work at covered employment in the Industry with an Employer who participates in this Fund. If the Participant is otherwise eligible for employment with a contributing Employer but failed to work for such Employer for reasons of their own choosing and for more than four (4) weeks in any consecutive twelve (12) month period [a total of more than twenty (20) regular work days - Monday through Friday], then the Participant is considered as having "stopped working" unless the Participant is fully retired.

Self-payment is equal to the minimum amount the Trustees determine is necessary to support the Plan, reduced by any remaining accumulated dollars in the Participant's DB and HRA accounts.

Self-payments must be received at the Plan's Office by the 1st of the month **of the coverage quarter** for which the payment is due. All Notices are sent to the last known address on file at the Third-Party Administrator's Office. It is

the Participant's responsibility to report any change in address immediately to the Third-Party Administrator.

Eligibility by means of self-payments can be continued for a maximum of four consecutive coverage quarters. However, if the industry is suffering from an extended period of widespread unemployment, the Trustees may temporarily allow self-payment of contributions for more than four consecutive coverage quarters. **If a Participant fails to maintain eligibility by making self-payments, any balance in the Participant's DB and HRA accounts will be reduced to zero**.

When the Participant is eligible by self-payments, the Participant and their eligible Dependents are covered for the same benefits as all other Fund Participants; all normal Plan provisions apply.

REINSTATEMENT

If a Participant's coverage ceases because of insufficient hours, the Participant may qualify for coverage at the beginning of a coverage quarter once the Participant has at least $3,030 accumulated in the Participant's accumulated DB and HRA accounts, within a 12 consecutive month period.

If a Participant's coverage ceases because the Participant stopped working for a covered Employer, when work was available, or the Participant was promoted to a category not covered by a Collective Bargaining Agreement, the Participant will be required to satisfy the initial eligibility requirements.

Participants Promoted to Non-Bargaining Category for Contributing Employer

Participants promoted to a category not covered by the Collective Bargaining Agreement for a Contributing Employer may use their HRA account to pay any eligible IRS reimbursable medical expense for the Participant and or the Participant's Dependents as long as the Participant reasonably represents to the Third Party Administrator the Participant has group health plan coverage for the Participant and the Participant's Dependents. Both the Participant and the Participant's Dependents must be covered under a group health plan for both the Participant and the Dependents to be able to use the HRA account. A Participant may have group health plan coverage in one of the following ways:

1. Participant is working in a non-bargaining capacity for a Contributing Employer and the Contributing Employer contributes a monthly premium to this Plan on the Participant's behalf through a Participation Agreement with the Fund. During the period when the Contributing Employer is paying contributions on behalf of the Participant to this Fund, the Participant and the Participant's Dependents may use their HRA account. The Participant must provide Attachment 4 to the Third Party Administrator before an HRA reimbursement request can be made and within 30 days of Participant's promotion to a category not covered by the Collective Bargaining Unit.

2. Participant is working for a Contributing Employer and the Contributing Employer covers the Participant under a group health plan. Participant must provide reasonable representation (See Attachment 4) to the Third Party Administrator of the Participant and any Dependent's coverage before an HRA reimbursement request can be made and within 30 days of Participant's promotion to a category not covered by the Collective Bargaining Unit.

3. Participant is working for a Contributing Employer and has coverage under a group health plan through an employer of Participant's spouse. Participant must provide reasonable representation (See Attachment 4) to the Third Party Administrator of the Participant and any Dependent's coverage before an HRA reimbursement request can be made and within 30 days of Participant's promotion to a category not covered by the Collective Bargaining Unit.

The Participant may permanently opt out of or waive future reimbursements from the HRA upon notice to the Third Party Administrator (See Attachment 4). The Participant must notify the Third Party Administrator immediately if the Participant or any Dependents no longer have coverage as set forth above.

At no time will a Participant or Dependent be able to use the HRA account if the Participant and Dependents do not have group health plan coverage that complies with the group market reform under the Affordable Care Act. Obtaining insurance through individual market policies through the Affordable Care Act health insurance exchanges or marketplaces will not be deemed coverage under a group health plan to allow the Participant and Dependents to use the HRA account.

A Participant may choose (See Attachment 4), within 30 days of a promotion to a category not covered by the

Collective Bargaining Agreement, to request their DB and HRA accounts be frozen for the quarter commencing after they were promoted and if they return to the Bargaining Unit and make themselves available for full time employment, they should have, upon their request in writing to the Third-Party Administrator within 30 days of their return to the Bargaining Unit, their accounts unfrozen.

ELIGIBILITY FOR EMPLOYEES IN COVERED EMPLOYMENT OUTSIDE THE LOCAL'S JURISDICTION

When an eligible Employee leaves the jurisdiction of a Local Union signatory to a Collective Bargaining Agreement requiring contributions to this Fund to work in the trade at covered employment under the jurisdiction of another Carpenters Local Union, the Employee's eligibility in this Plan is governed by the requirements of this section of the Eligibility Rules.

JURISDICTION WITHOUT RECIPROCITY

When a Participant leaves the jurisdiction of a signatory Local Union to work at covered employment under the jurisdiction of another Carpenters Local Union that DOES NOT have a Reciprocal Agreement with this Health and Welfare Fund, the Participant's eligibility (and that of any eligible Dependents) terminates on the earlier of:

1. The first day of the month in which the Participant's accumulated work credits do not meet the quarterly contribution requirement determined by the Trustees; or

2. The date in which the Participant becomes eligible for benefits under any other group health care plan; or

3. **Provided that the Participant filed a written request with the Third-Party Administrator's Office prior to the date the Participant left**, the last day of the month in which the Participant ceased working at covered employment in a signatory Local Union jurisdiction.

If the Participant elected to file the written request described in paragraph (3) above and returns to the signatory Local Union's jurisdiction within 12 calendar months, the Participant's eligibility will be reinstated in accordance with this section of the Rules and the Participant will not be subject to the "Initial Eligibility" requirement.

RETURN TO JURISDICTION (REINSTATEMENT OF ELIGIBILITY)

When an Employee returns to covered employment in the signatory Local Union's jurisdiction, their eligibility will be reinstated in this Plan on the date they first perform covered employment for an Employer required to contribute to this Fund, provided:

1. The Employee filed the required written request and terminated their prior eligibility according to the procedure described in paragraph (3) above; and

2. The Employee returns to covered employment in a signatory Local Union's jurisdiction within twelve (12) calendar months of their eligibility being terminated; and

3. The Employee has at least $3,030 of Employer contributions made to the Fund on their behalf for work performed during the three (3) calendar months immediately prior to the month in which they left the signatory Local Union's jurisdiction and termination occurred.

If the Employee failed to file the required written request, the Employee must satisfy the remaining reinstatement requirements within six (6) months after their eligibility terminates.

If the Employee fails to meet these requirements or if they meet the requirements but return more than twelve (12) months after their eligibility terminates, then the Employee must meet the requirements under "Initial Eligibility" in these Rules to reinstate eligibility.

JURISDICTION WITH RECIPROCITY

The Trustees of the Five Rivers Carpenters District Council Health and Welfare Fund have entered into Reciprocal Agreements with the Trustees of similar Health and Welfare Funds operating in the jurisdiction of other Carpenters Local Unions. Under these Agreements, contributions for hours worked at covered employment in the jurisdiction of another Carpenters Local Union may be transferred to this Fund for use in continuing a Participant's eligibility.

The amounts to be transferred and the way those transfers are credited to the Employee’s records are governed by the

Reciprocity Agreements and by the administrative procedures adopted by the Trustees from time to time. An Employee should inquire about the availability of Reciprocal transfers at their local Union Hall **BEFORE** they leave the signatory Local Union's jurisdiction.

CONTINUATION OF ELIGIBILITY FOR DEPENDENTS IN THE EVENT OF AN EMPLOYEE'S DEATH

If the Employee dies, eligibility for the surviving Dependents will continue automatically, without self-contribution, so long as they continue to meet the definition of Dependent until the later of:

1. The normal eligibility termination date based on the employee's contribution records and his/her DB and HRA accounts; or,

2. The last day of the quarter in which the Employee dies.

Eligibility for surviving Dependents may then be continued under "COBRA Continuation Options". See below and Exhibit A for more information.

TERMINATION OF ELIGIBILITY FOR EMPLOYEES AND THEIR DEPENDENTS WHEN ENTERING MILITARY SERVICE

This group health plan fully complies 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 services. The maximum period of coverage for you or your dependents under such an election shall be the lesser of:

- The 24-month period beginning on the date on which your absence begins; or
- The period beginning on the date on which your absence begins and ending on the day after the date on which you fail 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.

If you elect to continue health plan coverage under the plan during a period of active service in the uniformed services, you may will be required to pay the self-payment rate. This does not apply if you perform service in the uniformed services for less than 31 days. When that is the case, your employer will pay for the coverage. Continuation of 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).

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 more complete explanation of your rights and obligations under USERRA.

If an Employee does not elect coverage as provided above, an Employee's DB and HRA accounts, if any, will be kept on the records of the Fund, provided the Employee notifies the Third-Party Administrator's Office in writing that they are entering the Armed Forces of the United States. Such accumulated eligibility will be made available to the Employee

upon discharge and return to work for a contributing Employer. If covered employment is available and the Participant is physically fit, they must return to work for a contributing Employer within ninety (90) days after a discharge to retain their rights to their eligibility. The Employee's eligibility and that of their Dependents, if any, is then reinstated on the day they return to work for a contributing Employer. If they fail to return to work for a contributing Employer within ninety (90) days from the date they are discharged, the Employee must again satisfy the Initial Eligibility requirements of these Rules.

The Employee's accumulated accounts will be adjusted on an $1,010 per month basis to reflect the above the same as if it were initial eligibility.

REINSTATEMENT OF ELIGIBILITY

Employees

Reinstatement rules are the same as initial eligibility rules. If the Employee is not actively at work due to disability on the date the Employee would otherwise reinstate their eligibility, the Employee will not become eligible for benefits until they return to active employment as described in that section. The Employee and their eligible Dependents, if any, become eligible for all other plan benefits immediately on their normal effective date.

Dependents

A Dependent child who loses eligibility for reasons other than age may have eligibility reinstated on the first day of the quarter after which the child again meets all the requirements of the Dependent definition.

EXTENDED SELF-PAYMENT PROGRAM (RETIREE PROGRAM – SEE ATTACHMENT 1)

Retirees are not eligible for any DB type plan benefits which are life insurance coverage, AD&D benefits and short term disability benefits, and the Employer Contributions in the DB account will be transferred into the HRA account at retirement.

General Eligibility Requirements

Retiree elects not to receive Plan benefits
Each normal or early Retired Employee may elect not to continue HRA benefit coverage for himself and his Dependents through this Plan under the Retiree Program provided he meets all of the following requirements:

1. He is at least 55 years old; and

2. He has been eligible in the Plan at least ten uninterrupted years immediately prior to his request for coverage under this (Retiree) Program; and

3. He is receiving benefits from a Carpenter's Pension Plan or from Social Security; and

4. He has ceased working in the Carpentry industry, and he elects not to receive Plan benefits.

Note: Any remaining balance in the retirees HRA account can be used to pay any eligible IRS reimbursable medical expense for the retiree and/or his Dependents including being reimbursed for other medical coverage even if the retiree does not sign up for the extended self-payment program. The retiree may permanently opt out of or waive future reimbursements from the HRA upon notice to the Third Party Administrator.

Retiree elects to receive Plan Benefits
Each normal or early Retired Employee may continue coverage for himself and his Dependents through this Plan under the Retiree Program (this would be under the "retiree contribution rate" for the retiree and his spouse) provided he meets all of the following requirements:

1. He is at least 55 years old; and

2. He has been eligible in the Plan at least ten uninterrupted years immediately prior to his or her request for coverage under this (Retiree) Program; and

3. He is receiving benefits from a Carpenter's Pension Plan or from Social Security; and

4. He has ceased working in the Carpentry industry, and the member has elected to remain in the plan.

After the member is no longer eligible to receive Plan benefits under this plan, the spouse, if he/she elects, may continue coverage and self-pay for coverage for a period of five (5) years or until he/she is eligible for Medicare, whichever occurs first. The spouse may permanently opt out of or waive future reimbursements from the HRA upon notice to the Third Party Administrator.

The self-payment amounts required for eligibility in the Retiree Program are the retiree rates as determined by the board of trustees. Self-payments must be received at the Third-Party Administrator's Office by the **28th of the month before the coverage month** for which payment is due. All Notices are sent to the last known address on file at the Third-Party Administrator's Office. It is the responsibility of the Participant to see that any address changes are reported immediately.

If the Employee is eligible to participate in this (Retiree) Program, they must exercise the option when first eligible to do so. If they do not exercise their option to participate in the (Retiree) Program immediately upon retirement, they will not be allowed to begin participation at a later date.

If a Participant engages in any work for remuneration of any kind in the Carpentry industry, their eligibility and that of their dependents shall be as follows:

1. If the work for remuneration is in the Carpentry industry for an employer that does not contribute on behalf of the Participant to this Plan, the Participant's eligibility and that of their dependents shall cease at the end of the month the Participant commenced such work.

2. If the work for remuneration is in the Carpentry industry for a Contributing Employer who participates in this Fund on behalf of the Participant, and the Participant is self-paying pursuant to the "Retiree elects to receive Plan Benefits" section above, the Participant may be allowed to continue self-payments at the retiree rate (as determined by the board of trustees) while the Participant is actively working. Self-payment will be at the retiree rates (as determined by the board of trustees) minus any dollars in the HRA account due to contributions received for the Participant. The reduction by any dollars in the HRA account due to contributions received for the Participant will occur the first of the month following the month the contributions were RECEIVED by the Fund Office.

Month A	The Following Month B	The Following Month C
You go to work for a Contributing Employer and are self-paying at the retiree rate.	The Contractor reports your contributions worked for prior Month A to THIRD PARTY ADMINISTRATOR. You continue to self-pay at the retiree rate.	You may reduce your self-payment of the retiree rate by any dollars in your HRA account due to contributions received in Month B.

Self-payment must be received by the **28th of the month before the coverage month** for which payment is due. When Participant's choose to quit working, they will continue retirement under the "**Retiree elects to receive Plan Benefits**" provisions above.

The Trustees annually review the Retiree Program for purposes of termination, extension or modification. All persons electing to use such program should govern themselves accordingly.

RETIRED MEMBERS NOT ELIGIBLE FOR THE EXTENDED SELF PAYMENT PROGRAM

Retirees' are not eligible for any DB type plan benefits which are life insurance coverage, AD&D benefits and short term disability benefits, and Employer contributions in the DB account will be transferred into the HRA account at retirement. If a retiree is not eligible for the Extended Self Payment Program provisions provided above, the following provisions shall apply.

General Eligibility Requirements

Each normal or early Retired Employee may elect to continue coverage for himself through this Plan under this Program provided he continues to meet all of the following requirements:

1. He is retired and is receiving benefits from a Carpenter's Pension Plan or from Social Security; and

2. He has a HRA account with enough assets to pay the monthly HRA premium and

3. He has ceased working in the Carpentry industry.

   Note: The HRA account can be used to pay any eligible IRS reimbursable medical expense for the retiree and or his Dependents if the HRA account does not have enough assets to pay the monthly premium or if the retiree does not elect to continue coverage under the Plan. The retiree may permanently opt out of or waive future reimbursements from the HRA upon notice to the Third Party Administrator.

Once the retiree's HRA account does not have enough assets to pay the monthly HRA premium, the retiree may be eligible for COBRA benefits.

Once a Retiree is entitled to Medicare benefits, the Plan will stop providing covered benefits regardless of the retirees DB and HRA account balances and whether or not the retiree chooses to purchase Medicare Part B coverage.

CHANGE OF ELIGIBILITY RULES

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

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

Participants must remember: changes in employment may have an effect on Employer contributions paid on the Employee's behalf. For example, Employer contributions cease in the event the Employee:

1. Changes job classifications from covered to non-covered employment, even if that employment is with the same employer, or

2. Change employment from a participating to a non-participating employer.

The Employee and their Dependents may obtain, upon written request to the Union Office, information as to the address of a particular employer and whether that employer is required to pay contributions to the Fund for this Plan.

ELIGIBLE CLASSES OF DEPENDENTS

A Dependent is any one of the following persons:

1. A covered Employee's lawful Spouse and children from birth to the limiting age of 26 years.

   The term "Spouse" shall mean the person recognized as the Participant's spouse by virtue of a certificate issued by a governmental body to the Participant acknowledging the Participant is married to the spouse. The Plan's Third-Party Administrator may require documentation proving a legal marital relationship.

   The term "children" shall include natural children, born of the eligible employee, adopted child or children placed with a covered Employee in anticipation of adoption. A child up to age 26 is eligible for coverage through this Plan regardless of marital status, employment status, or existence of other coverage. However, if the child has coverage through their own employer or through their own spouse, then this coverage will pay benefits as secondary to that coverage as outlined in the Coordination of Benefits section of this Summary Plan Description.

   The phrase "child placed with a covered Employee in anticipation of adoption" refers to a child whom the Employee intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

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

Any child of a Plan Participant who is an alternate recipient under a Qualified Medical Child Support Order shall be considered as having a right to Dependent coverage under this Plan. A participant of this Plan may obtain, without charge, a copy of the procedures governing Qualified Medical Child Support Order (QMCSO) determinations from the Plan's Third-Party Administrator.

A foster child or stepchild is **not** an eligible Dependent under this Plan.

2. A covered Dependent is also a child who reaches the limiting age and is Totally Disabled (prior to reaching age 26), incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered Employee for support and maintenance and unmarried. The Third-Party Administrator will require proof of the child's Total Disability and dependency within 60 days of the child reaching 26 years of age.

   After receipt of initial proof, the Plan's Third-Party Administrator may require subsequent proof after the child reaches age 26, but not more than once each year. The Third-Party Administrator reserves the right to have such Dependent examined by a Physician of the Third-Party Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

   These persons are excluded as Dependents: other individuals living in the covered Employee's home, but who are not eligible as defined; the legally separated or divorced former Spouse of the Employee; any person who is on active duty in any military service of any country (over the age of 26 for dependent children); or any person who is covered under the Plan as an Employee.

   If a person covered under this Plan changes status from Employee to Dependent or Dependent to Employee, and the person is covered continuously under this Plan before, during and after the change in status, credit will be given for deductibles and all amounts applied to maximums.

   If both mother and father are Employees, their children will be covered as Dependents of the mother or father, but not of both.

ELIGIBILITY REQUIREMENTS FOR DEPENDENT COVERAGE

A family member of an Employee will become eligible for Dependent coverage on the first day that the Employee is eligible for Employee coverage and the family member satisfies the requirements for Dependent coverage.

At any time, the Plan's Third-Party Administrator may require proof that a Spouse or a child qualifies or continues to qualify as a Dependent as defined by this Plan.

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 by paying the self-pay rate for the employee. If the employee for any reason fails to return from the leave, the employer may recover from the employee that premium 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 the employer, the COBRA qualifying event occurs at that time.

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

FUNDING

Cost of the Plan

The Five Rivers Carpenters District Council Health and Welfare Fund pays the entire cost of Employee and Dependent coverage under this Plan from payments received from contributing employers pursuant to the terms of the Collective Bargaining Agreement between the Employer and the signatory Carpenters Local Unions.

ENROLLMENT

Enrollment Requirements

A Participant must enroll for coverage by completing, submitting and having the Enrollment Form accepted by the Fund Office. A newborn child of a Participant will be automatically covered from birth. However, the member must add the child to their Enrollment Form and provide a copy of a birth certificate to the Third-Party Administrator within 31 days of the child's birth.

When Employee Coverage Terminates

Employee coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Employee may be eligible for COBRA continuation coverage; for a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled COBRA Continuation Options):

1. Failure to meet the requirements for continuing eligibility as shown in the Eligibility Rules, including a failure to make any self-payment of contributions in a timely manner; or

2. Termination of the coverage classification under which you were continuing your eligibility; or

3. Termination of the Plan itself.

When Children and Dependent Coverage Terminates

A dependent's coverage will terminate on the earliest of these dates (except in certain circumstances, a covered child or Dependent may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled COBRA Continuation Options):

1. The date the Plan, child or Dependent coverage under the Plan is terminated.

2. The date that the Employee's coverage under the Plan terminates for any reason including death. (See the COBRA Continuation Options.)

3. The date the eligible class is terminated.

4. On the first of the month next following the date the child or Dependent fails to meet the definition of covered child or Dependent. (See the COBRA Continuation Options.)

5. Upon failure of the Member to meet the requirements for continuing eligibility as shown in the Eligibility section, including failure to make any self-payment of contributions in a timely manner.

SCHEDULE OF BENEFITS

Verification of Eligibility (800) 847-0113 or (319) 366-3623.
Call the above number to verify eligibility for Plan benefits **before** the charge is incurred.

MEDICAL BENEFITS

Refer to Exhibit A for the Wellmark Summary Plan Description for the medical benefits. Certain items not covered by the Wellmark Summary Plan Description are below. If any provision of this Summary Plan Description and Exhibit A Wellmark Summary Plan Description disagree, this Summary Plan Description shall control.

PLAN EXCLUSIONS AND LIMITATIONS

The following exclusions and general limitations apply to all benefits provided by the Five Rivers Carpenters District Council Health and Welfare Fund unless specifically waived by a particular benefit section.

ILLEGAL OCCUPATION OR COMMISSION OF FELONY OR INDICTABLE MISDEMEANOR

The Fund will not be liable for loss to which a contributing cause was the commission of or attempt to commit a felony or indictable misdemeanor by the person whose injury or sickness is the basis of claim, or to which a contributing cause was such person's being engaged in an illegal occupation, felony or indictable misdemeanor such as operating a motor vehicle while under the influence of alcohol or drugs.

PHYSICAL CONTESTS

Benefits under this Plan will not be paid for injuries sustained in a physical contest such as boxing, wrestling, hard man or stunt man contests.

EXCLUSIONS

For all Benefits shown in the Schedule of Benefits or the Wellmark Summary Plan Description in Exhibit A, a charge for the following is NOT covered:

1. **Extraordinary risks.** Voluntary acceptance of extraordinary risks such as speed contests or fighting.
2. **Foreign travel.** Care, treatment or supplies out of the U.S. if travel is for the sole purpose of obtaining medical services, drugs or supplies.
3. **Government coverage.** Care, treatment or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or when otherwise prohibited by law.
4. **Growth hormones.** Charges for growth hormones.
5. **Hair loss.** Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician.
6. **Illegal acts.** Charges for services received as a result of Injury or Sickness caused by or contributed to by engaging in an illegal act or occupation; by committing or attempting to commit any crime, criminal act, assault or other felonious or indictable misdemeanor behavior; or by participating in a riot or public disturbance. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.
7. **Impotence.** Care, treatment, services, supplies, mental counseling, physical therapy, prosthesis, or medication in connection with treatment for impotence or sexual dysfunctions (including penile prosthesis to treat impotence).
8. **Liability of other coverage.** Benefits under this Plan are considered secondary and excess coverage, including but not limited to any automobile insurance or common carrier's liability (such as bus or commercial airline). No payment shall be made until proof is submitted to and judged acceptable by the Trustees that a proper claim has been made for other coverage. Normal Plan benefits shall be paid if other coverage has been denied for reasons other than the availability of benefits under this Plan or shall be coordinated with other coverage payments, if any.
9. **Marital counseling.** Treatment or services for or in connection with marriage, family, child, career, social adjustment, pastoral or financial counseling.
10. **No charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.
11. **Non-compliance.** Expenses incurred due to or as a consequence of non-compliance with any applicable state or federal statute or regulation.
12. **No obligation to pay.** Charges incurred for which the Plan has no legal obligation to pay.

13. **Occupational.** Care and treatment for expenses incurred because of disease, defect or accidental Injury which occurs during or arises out of any occupation for wage or profit. If the Covered Person's claim under Workers' Compensation or any Occupational Disease Law is rejected by an agency of competent jurisdiction, the Injury or Sickness will not be considered work related and payment will be made.
14. **Other coverage.** Services, treatment or supplies which are payable or furnished under any policy of insurance or other medical benefit plan or service plan for which the Trustees shall, directly or indirectly, have paid for all or a portion of the costs.
15. **Plan design excludes.** Charges excluded by the Plan design as mentioned in this document.
16. **Pregnancy of daughter.** Care and treatment of Pregnancy and Complications of Pregnancy for a dependent daughter only.
17. **Relative giving services.** Professional services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a Spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.
18. **Services before or after coverage.** Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan.
19. **Third party involvement.** The Plan does not provide for the payment of medical or dental expenses incurred by a Plan Participant or Dependent which involve the acts of omissions of a Third Party or Parties. The Fund may advance to a Participant and/or Dependent medical or dental cost incurred by the Participant and/or Dependent which would have been paid under the Plan had a Third Party or Parties not been involved, providing the Participant and/or Beneficiary agree in writing to the terms and conditions established by the Fund for such advancements.
20. **Vision perception training.** Charges for vision perception training.
21. **War.** Any loss that is due to a declared or undeclared act of war, or any act thereof, or military or naval services of any country.

PRESCRIPTION BENEFITS

PHARMACY DRUG CHARGE

Participating pharmacies have contracted with the Plan to charge Covered Persons reduced fees for covered Prescription Drugs.

CO-PAYMENTS – WHEN THE PRESCRIPTION IS PURCHASED USING THE PRESCRIPTION DRUG CARD

The co-payment is applied to each covered pharmacy drug and is shown in the schedule of benefits. **The co-payment amount is not a covered charge under the medical Plan.**

WHEN THE PRESCRIPTION IS PURCHASED WITHOUT USING THE PRESCRIPTION DRUG CARD

If a drug is purchased and the Covered Person's ID card is not used, reimbursement can be obtained by sending in a paper claim to the Fund's Pharmacy Benefits Manager, OptumRx (formerly known as Catamaran). Claim forms can be obtained at the Fund Office or online at **www.5RCbenefits.com.**

Covered Prescription Benefits

Immunizations and Vaccinations provided and/or administered are covered under the immunization and vaccination benefits.

Prescription Drugs

1. All drugs prescribed by a Physician that require a prescription either by federal or state law. This excludes any drugs stated as not covered under this Plan.

2. All compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity.

3. Insulin and other diabetic supplies when prescribed by a Physician (i.e., glucometers, insulin needles and syringes, insulin pump needles, lancets, and lancet devices).

4. Allergy medications.

5. Acne medications – to age 37.

6. Bee sting injections/ANA kits (limited to two per year).
7. Chemotherapy agents.
8. COX-2 Inhibitors.
9. Fluoride.
10. Folic Acid.
11. Fosamax 70 mg weekly.
12. Hypnotics/Sedatives.
13. Immunosuppressants.
14. Migraine medications.
15. Protease inhibitors.
16. Urine testing supplies.
17. Zyvox.

LIMITS TO THE PRESCRIPTION DRUG BENEFIT

This benefit applies only when a Covered Person incurs a covered Prescription Drug charge. The covered drug charge for any one prescription will be limited to:

1. Refills only up to the number of times specified by a Physician.
2. Refills up to one year from the date of order by a Physician.

The following drugs will also be covered, but **Prior Authorization is Required**:

1. Copaxone.
2. Enbrel.
3. Factor.
4. Gleevec.
5. Hepatisis Injections.
6. IVIG's.
7. Specialty Drugs.
8. Wellbutrin 150 mg.

Note: This list is periodically updated and may not represent all drugs requiring a prior authorization.

EXPENSES NOT COVERED

This benefit will not cover a charge for any of the following:

1. **Administration.** Any charge for the administration of a covered Prescription Drug.
2. **Anabolic steroids.** Any charges for anabolic steroids.

3. **Appetite suppressants.** A charge for appetite suppressants, anorectics, nutritional supplements and dietary supplements.

4. **Consumed on premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed.

5. **Contraceptives.** Charges for contraceptives including implantable contraceptives, injectable contraceptives (i.e., Depo-Provera), NuvaRing, oral contraceptives, the contraceptive patch, diaphragms, foam and devices for contraceptive purposes.

6. **Cosmetic.** Charges for cosmetic products, except as specifically listed as covered.

7. **Devices.** Devices of any type, even though such devices may require a prescription. These include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, or any similar device.

8. **Experimental.** Experimental drugs and medicines, even though a charge is made to the Covered Person.

9. **FDA.** Any drug not approved by the Food and Drug Administration.

10. **Government coverage.** Any drugs for which reimbursement is available under any other group program or government program.

11. **Hair growth.** Charges for hair growth products.

12. **Impotence.** A charge for impotence medication.

13. **Infertility.** A charge for infertility medication.

14. **Inpatient medication.** A drug or medicine that is to be taken by the Covered Person, in whole or in part, while Hospital confined.

15. **Investigational.** A drug or medicine labeled: "Caution - limited by federal law to investigational use".

16. **Medical exclusions.** A charge excluded under Medical Plan Exclusions set forth in Exhibit A.

17. **No charge.** A charge for Prescription Drugs which may be properly received without charge under local, state or federal programs.

18. **Non-legend drugs.** A charge for FDA-approved drugs that are prescribed for non-FDA-approved uses.

19. **No prescription.** A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin, the syringes or needles for its administration and diabetic supplies.

20. **Over-the-counter.** Over-the-counter medications (except insulin, needles and syringes for its administration, and diabetic supplies).

21. **Refills.** Any refill that is requested more than one year after the prescription was written or any refill that is more than the number of refills ordered by the Physician.

22. **Smoking cessation.** A charge for smoking cessation drug.

23. **Syringes and needles.** Charges for miscellaneous syringes and needles.

OptumRx (formerly known as Catamaran) Mail Order program is available to eligible members and their families for maintenance pharmaceuticals. This will be for a 90-day supply with the following co-pays:

$0 for **generic** drugs

$40 or 20% whichever is greater for **brand** drugs

You should note that when you obtain your drugs, either generic or brand through your retail pharmacy, there will be no change in your coverage or co-pays. Also, **all mail order co-pays will be for a 90-day supply.** When you do

switch over to mail order for a maintenance pharmaceutical, be sure you have a two to three-week drug supply on hand during this transition.

A **mandatory** program through OptumRx (formerly known as Catamaran) that utilizes their **"BriovaRx"** pharmacy, for **high cost specialty medications (injectable or tablet),** is now available. Your co-payment is $20 or 20% co-pay, whichever is greater, with a maximum out of pocket of $100 per prescription or refill at BriovaRx. You may call OptumRx at 1-888-354-0090.

COVERAGE FOR PRENATAL VITAMINS

A prescription from your doctor will be required. There will be a $0 co-pay at retail or mail order. Mail order co-pays are for a 90-day supply. Previously these vitamins were available at retail for 100% co-pay. Those that are eligible for this benefit are female members or a spouse of a male member.

PRIOR AUTHORIZATION

Prior authorization ensures higher cost medications are prescribed appropriately. While this program affects relatively few people (less than 2% of the population), there is the potential for significant savings for inappropriate prescribing.

The program monitors certain prescription drugs and their costs so you can get the right drug at the right cost. It works much like healthcare plans that approve certain medical procedures before they're done, to make sure you're getting tests you need: If you're prescribed certain medicine, that drug may need a "prior authorization." ***It makes sure you're getting a cost-effective drug that works for you.***

In this program, ***your own medical professionals are consulted.*** When your pharmacist tells you that your prescription needs a prior authorization, it simply means that more information is needed to see if your plan can cover the drug. Only your doctor (or sometimes a pharmacist) can provide this information and request a prior authorization.

It is the Trustees expectation that each of these changes will result in savings to the Fund, thereby helping your benefit dollars go further. Some of these features will also offer savings to you and your family members.

If you have questions regarding Prior Authorization, call the number on your member card (1-888-354-0090).

VISION CARE BENEFITS

Vision care benefits apply when vision care charges are incurred by a Covered Person for services that are recommended and approved by a Physician or Optometrist.

BENEFIT PAYMENT

Benefit payment for a Covered Person will be made as described in the Schedule of Benefits. There is no deductible required by the Plan before Vision Care Benefits become payable.

VISION CARE CHARGES

Vision Care Benefits are divided into two main parts; the eye examination to determine what correction may be required and the fitting of any necessary corrective materials (lenses and frames). Services or supplies must be provided by an Optician, Optometrist, or Ophthalmologist to be considered Covered Expenses.

The Fund pays 100% of Covered Services up to a maximum of $200.00 per Covered Individual per each two calendar year period (i.e., the current "two calendar year period" is January 1, 2016 through December 31, 2017).

The Fund pays 100% of one routine vision exam each calendar year and one pair of eyeglass lenses per calendar year, with no calendar year benefit maximum, for eligible dependent children up to age 18. Expenses incurred or charges made must still be usual, customary and reasonable as defined in the Plan of benefits.

Covered services means if a Participant or Participant's dependent, while eligible under this Plan, incurs expense for vision care services which are performed by an ophthalmologist, optometrist, or optician, including exam, lenses, frames, contact lenses, and any required supplies, the Fund will pay for such services and supplies up to the maximum allowed under the Plan, except as noted below.

LIMITS

No benefits will be payable for the following:

1. **Before covered.** Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan.

2. **Excluded.** Charges excluded or limited by the Plan design as stated in this document.

3. **Frequency.** Examinations or materials more frequently than specifically provided.

4. **Health plan.** Any charges that are covered under a health plan that reimburses a greater amount than this Plan.

5. **Medical and surgical treatment.** Services, treatment or supplies related to medical or surgical treatment of the eyes.

6. **No prescription.** Charges for lenses ordered without a prescription.

7. **Orthoptics.** Charges for orthoptics (eye muscle exercises).

8. **Replacement.** Lenses, frames or contact lenses which are lost or broken except at the normal intervals when benefits are available.

9. **Services before or after coverage.** Services, treatment or supplies which are rendered or furnished before the date a person becomes initially eligible or after the date a person's eligibility terminates.

10. **Special procedures.** Charges for special procedures such as orthoptics, vision training or anise Konia.

11. **Sunglasses.** Charges for safety goggles (except for the Employee only as specifically provided) or sunglasses, including prescription type.

12. **Training.** Charges for vision training or subnormal vision aids.

13. Both normal glasses with frames or contact lenses more frequently than specifically provided. Vision care benefits are also subject to all General Plan Exclusions and Limitations.

DENTAL BENEFITS

This benefit applies when covered dental charges are incurred by a person while covered under this Plan.

BENEFIT PAYMENT

Each Calendar Year benefits will be paid to a Covered Person for the dental charges. Payment will be made as shown under Dental Care Benefits in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount.

Coverage for the following dental services will be provided in accordance with the Plan's current Schedule of Benefits, but will not be subject to the dental calendar year Maximum Benefit Amount for eligible dependent children up to age 18.

- Routine periodic examinations limited to two exams per Calendar Year. A re-evaluation is considered included in the primary procedure and is not payable separately.
- Complete mouth x-rays (posterior bitewing films and 14 periapical films plus bitewings) are allowed once during any three-year period for members age 13-18, in lieu of panorex x-ray.
- Full series bitewing x-rays (4) are allowed only twice in a Calendar Year.
- A panorex is allowable once during any three-year period in lieu of complete mouth x-ray.
- Vertical bitewings are payable up to eight films.
- Dental prophylaxis (cleaning) allowed twice in a Calendar Year. A child Prophylaxis will be allowed through age 13. An adult Prophylaxis will be allowed for age 14-18.

- Dental sealant application on permanent molars is allowed for eligible Dependent children under age 18 once during any five-year period. Permanent molars include teeth numbers 1, 2, 3, 14, 15, 16, 17, 18, 19, 30, 31, and 32. (Permanent molars with occlusal restoration are ineligible.)

MAXIMUM BENEFIT AMOUNT

The Maximum dental benefit amount is shown in the Schedule of Benefits. All payments under Dental Care Benefits are limited to the maximum amount shown in the Schedule of Benefits. The maximum amount applies to the Employee and each of their eligible Dependents separately.

The maximum amount for all covered expenses applies to payment for treatment in each calendar year and so is renewed each January 1st. Benefits not used in a prior year cannot be carried forward to increase the maximum amount for the next calendar year.

DENTAL CHARGES

Dental charges are the Usual, Customary and Reasonable Charges made by a Dentist or other Physician for necessary care, appliances or other dental material listed as a covered dental service.

A dental charge is incurred on the date the service or supply for which it is made is performed or furnished. However, there are times when one overall charge is made for all or part of a course of treatment. In this case, the "date of service" is the date the Dentist:

1. Took the impression and prepared the abutment for a prosthetic device (such as a full or partial denture); or

2. Prepared the tooth for a crown, inlay or onlay; or

3. Opened the tooth for root canal therapy.

The Plan does not consider the "date of service" the day services are completed or the day the prosthetic device is delivered.

TREATMENT IN PROGRESS WHEN ELIGIBILITY TERMINATES

The Plan will generally not pay for services and supplies furnished after the date the Covered Person's eligibility terminates. The Plan will pay for services or supplies related to the following covered expenses if the Treatment is rendered during the calendar month immediately after the termination date and the following conditions are met:

1. A prosthetic device (such as full or partial dentures) if the dentist took the impressions and prepared the abutment teeth while the patient was covered under the Plan;

2. A crown if the dentist prepared the tooth for the crown while the patient was covered under the Plan

3. Root canal therapy if the Dentist opened the tooth while the patient was covered under the Plan.

EXCLUSIONS

A charge for the following is not covered:

1. **Administrative costs.** Administrative costs of completing claim forms or reports or for providing dental records.

2. **Below standards.** Services or supplies which do not meet accepted standards of dental practice, including charges for services or supplies which are experimental in nature.

3. **Broken appointments.** Charges for broken or missed dental appointments.

4. **Cosmetic.** Services or supplies that are primarily cosmetic in nature, including charges for personalization or characterization of dentures.

5. **Duplicate.** Any duplicate appliance or prosthetic device.

6. **Excluded under Medical.** Services that are excluded under Medical Plan Exclusions, set forth in Exhibit A.

7. **Hygiene.** Oral hygiene, plaque control programs or dietary instructions.

8. **Implants.** Implants, including any appliances and/or crowns and the surgical insertion or removal of implants.

9. **Missing tooth.** Charges associated with the initial installation of dentures or bridgework replacing a tooth or group of teeth which were lost when not eligible for coverage under this Plan.

10. **Medical services**. Services that, to any extent, are payable under any medical expense benefits of the Plan, including removal of impacted teeth.

11. **Myofunction therapy.** Charges for myofunction therapy (correction of harmful habits).

12. **No listing.** Services which are not included in the list of covered dental services.

13. **Non-Dentist provider.** Treatment other than by a licensed dentist or licensed physician, except that scaling or cleaning of teeth and topical application of fluoride may be performed by a licensed dental hygienist if the treatment is rendered under the supervision and guidance of and billed for by the dentist.

14. **Not Dentally Necessary.** Services or supplies which are not necessary according to accepted standards of dental practice.

15. **Replacement.** Replacement of lost, missing or stolen appliances (both prosthetic devices and orthodontic appliances)

16. **Services before coverage**. Any services rendered, supply ordered or treatment plan begun before coverage became effective.

17. **Splinting.** Crowns, fillings or appliances that are used to connect (splint) teeth, or change or alter the way the teeth meet, including altering the vertical dimension, restoring the bite (occlusion) or are cosmetic.

18. **TMJ.** Non-Surgical treatment, procedures or appliances for TMJ.

SHORT TERM DISABILITY BENEFITS
For Bargaining Agreement Members Only

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

1. Total Disability starts while the Member is covered for this benefit.

2. Total Disability is being continuously treated by a Physician. (A chiropractor is not considered a physician for the purpose of disability benefits.) No benefits are payable for any period of time for which the Member is **not** under the regular care and attendance of a physician.

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

4. Total Disability (Totally Disabled) means the complete inability to perform any and every duty of the Member's occupation or of a similar occupation for which the person is reasonably capable due to education and training, as a result of Injury or Sickness.

5. Benefits will not be paid for any disability which starts while you are not working on a regularly scheduled basis due to lay-off, leave of absence or other reason.

6. Benefits will not be paid if you are collecting unemployment.

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

- History regarding when symptoms of sickness first appeared or accident happened;
- Diagnosis;
- Dates of treatment;
- Nature of treatment;
- Progress;
- Prognosis;
- Suitability for rehabilitation;
- Physician's signature, tax I.D. number and phone number.

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

BENEFIT PAYMENT

Benefits will be paid for a Total Disability up to a Weekly Benefit Limit as described in the Schedule of Benefits.
Benefits are payable as described in the Schedule of Benefits.
Benefits provided under this provision are not assignable.

PERIOD OF TOTAL DISABILITY

Period of Total Disability is the period of time that an Employee is Totally Disabled. New periods due to different causes must be separated by return to Active Work for at least one day.

SHORT TERM DISABILITY CLAIMS PROCEDURE

Following is a description of how the Plan processes Claims for benefits. A Claim is defined as any request for a Plan benefit, made by a claimant or by a representative of a claimant that complies with the Plan's reasonable procedure for making benefit Claims. The times listed are maximum times only. A period of time begins at the time the Claim is filed. Decisions will be made within a reasonable period of time appropriate to the circumstances. "Days" means calendar days.

Initial Claims

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

If, after extending the time period for a first period of 30 days, the Plan Administrator determines that it will still be unable, for reasons beyond the control of the Plan, to make a decision within the extension period, the Plan may extend decision making for a second 30-day period.

Appropriate notice must be provided to the claimant before the end of the first 45 days and again before the end of each succeeding 30-day period. This notice will explain the circumstances requiring the extension and the date the Plan Administrator expects to render a decision to the claimant. It will explain the standards on which entitlement to the benefits is based, the unresolved issues that prevent a decision, the additional issues that prevent a decision, and the additional information needed to resolve the issues.

The claimant will have 45 days to provide the information required.

Adverse Benefit Determinations

The Plan Administrator shall provide written or electronic notification of any adverse benefit determination. The notice will state:

The specific reason or reasons for the adverse determination.

Reference to the specific Plan provisions on which the determination was based.

A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary.

A description of the Plan's review procedures and the time limits applicable to such procedures. This will include a statement of the claimant's right to bring a civil action under section 502 of ERISA following an adverse benefit determination on review.

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

If the adverse benefit determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the adverse benefit determination and a copy will be provided free of charge.

If the adverse benefit determination is based on the Medical Necessity or Experimental and/or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

Appeals

When a claimant receives an adverse benefit determination, the claimant has 180 days following receipt of the notification in which to appeal the decision. A claimant may submit written comments, documents, records, and other information relating to the Claim. If the claimant so requests, he or she will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

The claimant will be notified of the determination on review of the adverse benefit determination no later than 45 days after receipt of the request for review, unless special circumstances require an extension of time for processing. In such a case, the claimant will be notified, before the end of the initial review period, of the special circumstances requiring the extension and the date a decision is expected. If an extension is provided, the Plan Administrator must notify the claimant of the determination on review no later than 90 days after receipt of the request for review.

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

- was relied upon in making the benefit determination;
- was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;
- demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or
- constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

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

DEATH BENEFITS

MEMBER'S DEATH BENEFIT

Death Benefit

Upon receipt of due proof of death, the Plan will pay the Death Benefit Amount shown in the General Summary of Scheduled Benefits in force on the Member's life at the time of his or her death. In no event will the total amount of Death Benefit in force for a Member exceed the Maximum shown in the General Summary of Scheduled Benefits.

The Death Benefit Amount payable with respect to an Insured Person will end at age 70 or when an Insured Person is no longer eligible under the Plan, whichever occurs first.

Payees

Benefits will be paid in one lump sum to the Member's beneficiary(ies) designation on file with the Third Party Administrator.

The Plan will not be liable for such payment after it is made.

DEPENDENT DEATH BENEFIT

Death Benefit

Upon receipt of due proof of death, the Plan will pay the Death Benefit Amount shown in the General Summary of Scheduled Benefits in force on the Insured Dependent's life at the time of his or her death. In no event will the total amount of Death Benefit in force for an Insured Dependent exceed the Death Benefit Maximum shown in the General Summary of Scheduled Benefits.

Payees

Benefits will be paid in one lump sum to the Member.

The Plan will not be liable for such payment after it is made.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE BENEFITS AND COVERAGES
[Bargaining Agreement Members Only]

PRINCIPAL SUM

As applicable to each Member, Principal Sum means the amount(s) under this Plan on the date of the Accident, as described in the General Summary of Scheduled Benefits. In no event will the total amount of Accidental Death and Dismemberment Insurance in force for a Member exceed the AD&D Insurance Maximum shown in the General Summary of Scheduled Benefits.

Any Accidental Death and Dismemberment Amount payable with respect to a Member will end at age 70 or when a Member is no longer eligible under the Plan, whichever occurs first.

ACCIDENTAL DEATH BENEFIT

If Injury to the Member results in death within 365 days of the date of the Accident that caused the Injury, the Plan will pay 100% of the Principal Sum.

ACCIDENTAL DISMEMBERMENT BENEFIT

If Injury to the Member results, within 365 days of the date of the Accident that caused the Injury, in any one of the Losses specified below, the Plan will pay the percentage of the Principal Sum shown below for that Loss:

For Loss of	**Percentage of Principal Sum**
Both Hands or Both Feet	100%
Sight of Both Eyes	100%
One Hand and One Foot	100%
One Hand and the Sight of One Eye	100%
One Foot and the Sight of One Eye	100%
One Hand or One Foot	50%
Sight of One Eye	50%

If more than one Loss is sustained by a Member as a result of the same Accident, only one amount, the largest, will be paid.

PARALYSIS BENEFIT

If Injury to the Member results, within 365 days of the date of the Accident that caused the Injury, in any one of the types of paralysis specified below, the Plan will pay the percentage of the Principal Sum shown below for that type of paralysis:

Type of Paralysis	**Percentage of Principal Sum**
Quadriplegia	100%
Paraplegia	50%
Hemiplegia	50%
Uniplegia	25%

If the Member suffers more than one type of paralysis as a result of the same Accident, only one amount, the largest, will be paid.

EXPOSURE AND DISAPPEARANCE

If by reason of an Accident occurring while a Member's coverage is in force under the Plan, the Member is unavoidably exposed to the elements and as a result of such exposure suffers a loss for which a benefit is otherwise payable under the Plan, the loss will be covered under the terms of the Plan.

If the body of a Member has not been found within one year of the disappearance, forced landing, stranding, sinking or wrecking of a conveyance in which the person was an occupant while covered under the Plan, then it will be deemed, subject to all other terms and provisions of the Plan, that the Member has suffered accidental death within the meaning of the Plan.

LIMITATION OF MULTIPLE BENEFITS

If a Member suffers one or more losses from the same Accident for which amounts are payable under more than one of the above Benefits provided under the Plan, the maximum amount payable under all of the Benefits combined will not exceed the amount payable for one of those losses, the largest of Accidental Death Benefit, Accidental Dismemberment Benefit, or Paralysis Benefit.

EXCLUSIONS

The Plan does not cover any loss caused in whole or in part by, or resulting in whole or in part from, the following:

1. suicide or any attempt at intentionally self-inflicted injury;

2. sickness, disease or infections of any kind, except bacterial infections;

3. travel or flight in or on (including getting in or out of, or on or off of) any vehicle used for aerial navigation on a regular schedule between established airports, if the Member is:

    a. performing, learning to perform or instructing others to perform as a pilot or crew member of any aircraft; or

    b. riding as a passenger in an aircraft owned, leased or operated by the Member's Contributing Employer;

4. declared or undeclared War, or any act of declared or undeclared War;

5. full-time active duty in the armed forces, National Guard or organized reserve corps of any country or international authority. (Loss caused while on short-term National Guard or reserve duty for regularly scheduled training purposes is not excluded.);

6. the Member being under the influence of drugs or alcohol or voluntary intake of poison, drugs, gas, or fumes or intoxicants, unless taken under the advice of a Physician; or

7. the Member commission of or attempt to commit a crime.

DEATH AND AD&D CLAIMS PROVISIONS

Notice of Claim

Written notice of claim must be given to the Third Party Administrator within 20 days after an Insured Person's loss, or as soon thereafter as reasonably possible. Notice given by or on behalf of the claimant to the Third Party Administrator at 1831 16th Avenue SW, Cedar Rapids, IA 52404 with information sufficient to identify the Insured Person, is deemed notice to the Third Party Administrator.

Claim Forms

The Third Party Administrator will send claim forms to the claimant upon receipt of a written notice of claim. If such forms are not sent within 31 days after the giving of notice, the claimant will be deemed to have met the proof of loss requirements upon submitting, within the time fixed for filing proof of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made and the Insured Person's name.

Proof of Loss

Written proof of loss must be furnished to the Third Party Administrator within 90 days after the date of loss. Failure to furnish such proof within the time required, will not reduce or deny any benefits if the proof is given as soon as reasonably possible. However, in no event, other than legal incapacity, will proof be given more than one year after the date of loss.

The Third Party Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the claimant.

Payment of Claims

Upon receipt of due written proof of death, payment for loss of life will be made to the Member's beneficiary as described in the Beneficiary Designation and Change provision of the General Provisions section.

Upon receipt of due written proof of loss, payments for all losses, except loss of life, will be made to (or on behalf of, if applicable) the Member. If a Member dies before all payments due have been made, the amount still payable will be paid to his or her beneficiary as described in the Beneficiary Designation and Change provision of the General Provisions section.

If any benefit is payable to the estate of a person, or if any payee is a minor or otherwise not competent to give a valid release for the payment, the Plan may make an initial payment, up to an amount not exceeding $5,000, to any relative by blood or connection by marriage of the payee who is deemed by the Plan to be equitably entitled thereto. Such payment does not discharge the Plan's liability for any remaining benefits payable under the Policy.

Any payment the Plan makes in good faith fully discharges the Plan's liability to the extent of the payment made.

Time of Payment of Claims

Benefits payable under the Policy for any loss will be paid immediately upon the Plan's receipt of due written proof of the loss or proof of death.

DEATH AND AD&D APPEALS

When a claimant receives an adverse benefit determination, the claimant has 180 days following receipt of the notification in which to appeal the decision. A claimant may submit written comments, documents, records, and other information relating to the Claim. If the claimant so requests, he or she will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

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

1. was relied upon in making the benefit determination;

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

3. demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or

4. constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

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

If the determination was based on a medical judgment, the Board of Trustees shall consult with a health care professional who was not involved in the original benefit determination. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally, medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified.

DEATH AND AD&D DATE INSURANCE ENDS

Member's Termination Date. A Member's coverage under the Death Benefit and Accidental Death and Dismemberment Benefit will end on the earliest of the following dates:

1. The date the Member ceases to be eligible under the Plan; or
2. The date Death Benefit and Accidental Death and Dismemberment Benefits are no longer offered under the Plan;
3. The Member reaches age 70; or
4. The date the Plan terminates.

With respect to Accidental Death and Dismemberment Benefits, termination of coverage will not affect a claim for a Covered Loss that occurs before or after such termination if that loss results from an Accident that occurred while the Member's coverage was in force under these provisions.

Dependent's Termination Date. A Dependent's coverage under the Death Benefit ends on the earliest of the following dates:

1. The date the Member's coverage under these benefits ends;
2. The date the person ceases to qualify as an Insured Dependent;
3. The date the Dependent coverage is no longer provided by the Plan;
4. The date the coverage terminates;
5. The date Death Benefits are no longer offered under the Plan;
6. The Dependent reaches age 70; or
7. The date the Plan terminates.

DEATH AND AD&D GENERAL PROVISIONS

Beneficiary Designation and Change. The Member's designated beneficiary(ies) is (are) the person(s) so named by the Member on the enrollment card submitted to the Third Party Administrator of the Plan. The Insured Dependent's beneficiary is the Member.

A legally competent Member over the age of majority may change his or her beneficiary designation at any time. The change may be executed, without the consent of the designated beneficiary(ies), by providing the Third Party Administrator with a written request for change. When the request is received by the Third Party Administrator, whether the Member is living or not, the change of beneficiary will relate back to and take effect as of the date of execution of the written request, but without prejudice to the Plan on account of any payment which is made prior to receipt of the request.

If there is no designated beneficiary, or if no designated beneficiary is living after the Member's death, the benefits will be paid, in equal shares, to the survivors in the first class of those that follow: The Member's (1) Spouse; (2) children; (3) parents; or (4) brothers and sisters. If no class has a survivor, the beneficiary is the Member's estate.

Physical Examination and Autopsy. The Plan at its own expense shall have the right and opportunity to examine the person of any individual whose loss is the basis of claim under the Plan as often as it may reasonably require during the review of the claim, and to make an autopsy in case of death where it is not forbidden by law.

Legal Actions. No action at law or in equity shall be brought to recover on these benefits prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of the Plan. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

Noncompliance with Plan Requirements. Any express waiver by the Plan of any requirements of the Plan will not constitute a continuing waiver of such requirements. Any failure by the Plan to insist upon compliance with the Plan provisions will not operate as a waiver or amendment of that provision.

Workers' Compensation. These benefits are not in lieu of and do not affect any requirements for coverage by any Workers' Compensation Act or similar law.

Assignment. A Member may assign all of his or her rights, privileges and benefits under these benefits. The Plan is not bound by an assignment until the Plan receives and files a signed copy. The Plan is not responsible for the validity of assignments. The assignee only takes such rights as the assignor possessed and such rights are subject to state and federal laws and the terms of the Plan.

DEATH AND AD&D DEFINITIONS

Accident means an event or occurrence that is sudden, unforeseen and unintended.

Dependent Child(ren) means the Member's unmarried children, including natural, or adopted children from the moment of placement in the home of the Member, under age 26 and primarily dependent on the Member for support and maintenance.

Any unmarried Dependent Children of the Member covered under the Plan before reaching the age limit specified above, who are incapable of self-sustaining employment by reason of mental or physical incapacity, and who are primarily dependent on the Member for support and maintenance, may continue to be eligible under the Plan beyond that age limit for as long as the Policy is in force, but only if they remain continuously covered under the Plan. The Plan may request that the Member submit satisfactory proof of the Dependent Child(ren) incapacity and dependency to the Plan within 60 days before the Dependent Child(ren) reach the age limit specified above. If the Member fails to furnish the requested proof before the Dependent Child(ren) reach the age limit, coverage for the Eligible Dependent Child(ren) will not be extended past the age limit. If coverage is extended, the Plan may request the Member submit satisfactory proof of the Dependent Child(ren)'s continued incapacity and dependency to the Plan on an annual basis.

If the Member fails to furnish the requested proof with 31 days of the request, coverage for the Dependent Child(ren) will terminate at the end of that 31-day period.

Hemiplegia means the complete and irreversible paralysis of the upper and lower limbs of the same side of the body.

Immediate Family Member means a person who is related to the Member in any of the following ways: spouse, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes stepparent), grandparent, brother or sister (includes stepbrother or stepsister), child (includes, legally adopted, stepchild, or foster child, and aunt, uncle, niece, nephew, or grandchild).

Injury means bodily injury that is the direct result of an Accident occurring while the Plan is in force with respect to the person whose injury is the basis of the claim and resulting directly and independently of all other causes in a covered loss.

Insured/Member means a person who is an employee who participates in and is eligible in the Five Rivers Carpenters District Council Health and Welfare Plan.

Insured Dependent means a Member's Dependent Child or a Member's Spouse.

Insured Dependent Child means the Member's Dependent Child.

Insured Person means the Member or an Insured Dependent.

Insured Spouse means the Member's Spouse.

Leg means the entire leg from the hip joint including the attached foot.

Limb means entire arm or entire leg.

Loss of hand or foot means complete severance through or above the wrist or ankle joint.

Loss of sight of an eye means total and irrecoverable loss of the entire sight in that eye.

Military means the armed land, sea or air force of a nation.

Paraplegia means the complete and irreversible paralysis of both lower limbs.

Physician means a licensed practitioner of the healing arts acting within the scope of his or her license, who is not: (a) the Insured Person; (b) an Immediate Family Member; c) residing with the Insured Person; or (d) retained by the Contributing Employer.

Quadriplegia means the complete and irreversible paralysis of both upper and lower limbs.

Schedule means the General Summary of Scheduled Benefits section of the Plan located on page 4 of the Summary Plan Description, as amended.

Spouse means the Member's lawful spouse (not including a spouse who is legally separated from the Member.)

Uniplegia means the complete and irreversible paralysis of one limb.

War means an armed conflict between the Military or Paramilitary forces of two (2) or more political entities.

DENTAL, VISION, DISABILITY AND HRA CLAIMS AND REIMBURSEMENT PROCEDURES

Following is a description of how the Plan processes Claims for benefits, except for medical benefits that are covered in Exhibit A. A Claim is defined as any request for a Plan benefit, made by a claimant or by a representative of a claimant that complies with the Plan's reasonable procedure for making benefit Claims. The times listed are maximum times only. A period of time begins at the time the Claim is filed. Decisions will be made within a reasonable period of time appropriate to the circumstances. "Days" means calendar days.

There are different kinds of Claims and each one has a specific timetable for either approval, payment, request for further information, or denial of the Claim. If you have any questions regarding this procedure, please contact the Third-Party Administrator.

HRA REIMBURSEMENT CLAIMS – GENERAL

Within thirty days after receipt by the Third-Party Administrator for a reimbursement claim from you, the Plan will reimburse you for your allowable medical care expenses provided you have completed the claim form in its entirety, provided an explanation of benefits from the medical, dental or vision provider, provided the required itemized statements/receipts along with the form, and that the Third-Party Administrator has approved the payment of the claim. **Submit these claims on the form found in Attachment 2.**

FILING A CLAIM

Instructions:

1. Complete Member Information (please print).
2. Complete Health Care Expense section as appropriate. Service must be incurred before being reimbursed.
3. Attach all required supporting documentation.

4. Proof of payment is required before any reimbursement will be considered. A void check is not acceptable.

HRA REIMBURSEMENT CLAIMS – ORTHODONTIC CARE, LASIK EYE SURGERY, HEARING AIDS AND DENTAL CLAIMS ABOVE THE MAXIMUM BENEFIT PAYABLE AMOUNT IN THE SCHEDULE OF BENEFITS

For the following claims, you may request the Third-Party Administrator to pay the claims directly to the provider. **Submit these claims on the form found in Attachment 3.**

- Orthodontic care
- Lasik eye surgery
- Hearing aids
- Dental claims above the Maximum Benefit Payable Amount in the Schedule of Benefits

If you incur one of the above listed procedures and do not have the ability to pay out of pocket for the services being rendered, you may submit an HRA claim form and the below information to the Third-Party Administrator. **You must already have incurred the procedure to be able to request this reimbursement method (with the exception of orthodontic care, discussed below). The Plan will not be able to pay one of the above claims prior to a Participant actually incurring the procedure and claim expense.** If your Provider is requesting payment for a claim upfront prior to the procedure taking place, and you cannot pay for the expense upfront, you may discuss these HRA Reimbursement Procedures with your provider to see if your provider will make an exception to the upfront payment. You may also request your current HRA balance with the Fund from the Plan Administrator as of a certain date. However, the Plan Administrator will never guarantee to a provider that you have enough in your HRA to be reimbursed for a procedure since your HRA balance fluctuates.

Orthodontia services may be paid before the services are provided and are deemed to be incurred when advance payment is made. Advance payment may be made in a lump sum or payments over time. You must submit documentation from the orthodontist showing the name of the person receiving the treatment, the beginning date of the treatment, the contracted amount, and the amount to be paid (Financial Agreement Contract, itemized statement and claim form are required). The Financial Agreement Contract with the Provider must be signed by the Provider and the Member.

FILING A CLAIM

Instructions:

1. Complete Member Information (please print).

2. Complete Health Care Expense section as appropriate. Service must be incurred before being reimbursed (with the exception of orthodontic care).

3. Attach all required supporting documentation.

Supporting Documentation:

The type of documentation described under either A or B below **must** be attached to the completed form.

A. Explanation of Benefits form (EOB): This is the form you receive each time you or a health care provider submit claims for payment of your health, dental or vision care plan. The EOB will show the amount of expenses paid or denied by the plan and the amount you must pay. For all health care expenses that are partially covered by your (or your spouse's) health, dental or vision care plans, you **must** attach an EOB.

B. All other Expenses: for expenses not covered at all by your (or your spouse's) health, dental or vision care plans, reimbursement request **will not be processed** without acceptable evidence of your expenses. A cancelled check is not considered acceptable evidence. Acceptable evidence includes receipts, which contain the following information:

- Name of person for whom the service/supply was provided
- Date expense was incurred
- Type of service (i.e. co-pay, deductible, coinsurance, dental, vision, RX, over the counter drugs
- Name of provider (i.e., physician, hospital, dentist, pharmacy)
- Amount of expense(s)
- Proof of payment

4. **Sign and Date the form (if submitted without employee signature claim(s) will be denied)**

5. Please make copies for your records, as these documents will not be returned.

6. Mail the completed form and attachments (s) to: **Five Rivers Carpenters District Council Health & Welfare Fund, 1831 16th Avenue SW, Cedar Rapids, IA 52404**

7. If you have any questions regarding your reimbursement account or claims, please call (800) 847-0113 or (319) 366-3623 or visit the member website address at www.5RCbenefits.com.

8. Checks will not be distributed until accumulated reimbursement amounts exceed $25.

GENERAL REIMBURSEMENT GUIDELINES:

- Reimbursement is not a guarantee that this payment is tax-free.
- Health care expenses reimbursed through this account cannot be deducted on your federal income tax return.
- Expenses can only be submitted for reimbursement if they were for you or for eligible individuals under this plan.
- Reimbursement will only be made in accordance with the provisions of the plan. You accept responsibility for the proper treatment of benefits paid under this plan with respect to eligibility, income tax reporting and liability.

Bills, invoices, and other statements from an independent party showing that the Allowable Medical Care Expenses have been incurred and the amounts of such expenses, together with any additional documentation that the Fund Administrator may request, must accompany the application. Except for the final reimbursement claim for a Period of Coverage, please note:

1. No claim for reimbursement may be made unless and until the aggregate claims for reimbursement are at least $25.
2. For over-the-counter medications, you must submit a prescription from a physician.
3. Claim payments may never exceed the balance remaining in the HRA.

NOTICE TO CLAIMANT OF ADVERSE BENEFIT DETERMINATIONS

Except with Emergency Care Claims, when the notification may be oral followed by written or electronic notification within three days of the oral notification, the Plan Administrator shall provide written or electronic notification of any adverse benefit determination. The notice will state, in a manner calculated to be understood by the claimant:

1. The specific reason or reasons for the adverse determination.
2. Reference to the specific Plan provisions on which the determination was based.
3. A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary.
4. A description of the Plan's review procedures and the time limits applicable to such procedures. This will include a statement of the claimant's right to bring a civil action under section 502 of ERISA following an adverse benefit determination on review.
5. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

6 If the adverse benefit determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the adverse benefit determination and a copy will be provided free of charge to the claimant upon request.

7 If the adverse benefit determination is based on the Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request

APPEAL PROCEDURE

If you want to appeal a decision by the Plan Administrator to deny, or partially deny, any claim for reimbursement, you must follow the procedures contained herein.

Internal Appeal

FOR MEDICAL CLAIMS, THE INTERNAL APPEAL PROCEDURES ARE INCLUDED IN THE WELLMARK SUMMARY PLAN DESCRIPTION, PAGE 51.

For all other claims, the procedure is as follows:

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. An adverse determination can be made by a denial in coverage, reduction in benefits, termination of coverage or loss of eligibility or recession of coverage due to fraud or intentional misrepresentation. You or your authorized representative, if you have designated one, may appeal an adverse benefit designation within 180 days from the date you are notified of the adverse benefit determination by submitting a written appeal.

All appeals need to be made to the Plan Office in writing:

Eastern Iowa Fringe Benefit Funds, Inc.
Five Rivers Carpenters District Council Health and Welfare Fund
1831 – 16th Ave SW
Cedar Rapids, IA 52404

An appeal can be made when there is new or additional information or rationale regarding the claim. You must enclose a statement setting out why you believe the appeal should be granted, noting the particular page and section of the Summary Plan Description you are relying on. You should enclose any material or supporting documentation which you believe supports your appeal, such as a doctor's or medical professional's statement or an article form a medical publication. No fees or expenses will be assessed the claimant for this appeal process. This claim will then be reviewed internally by the third party administrator.

You may request reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

The Plan Office has five business days to complete a preliminary review and notify the claimant that his appeal is incomplete if any of the following are missing or incorrect:

1. the claimant was covered under the plan at the time the health care item or service was provided
2. the adverse determination does not relate to eligibility
3. the claimant has exhausted the plan's internal appeal process
4. the claimant has supplied all the required information and completed forms

Note if the adverse decision is made due to the claimant not being covered or loss of eligibility, then this claim is not eligible for external appeal.

Once the claimant is informed that a preliminary review has determined that his information is incomplete, he has until the later of 48 hours or the end of the initial 180 days to resubmit the information.

Once the preliminary review by the Plan Office has determined that all of the four items have been supplied, then the claim will be reviewed by the third party administrator.

The Plan needs to inform the member of its benefit determination regarding urgent care within 72 hours after receipt of a claim regardless if it is determined to be adverse or not.

For benefit determinations that are not urgent, a determination must be made within 30 days after the claim is submitted, unless special circumstances require an extension of time for processing. Written notice of the extension shall be furnished to you prior to the termination of the 30 days.

The following items will be provided to the claimant with the decision:

Plan Member's Name
Name of person the claim was submitted
Date of Service
Service Provider
Cost of Service
Diagnosis code including what the code means
Treatment code including what the code means
Reason for adverse determination
A notice containing information about the second-level appeal process and a statement of the claimant's right to bring civil action under section 502 of ERISA following the second level appeal
A statement stating you may request reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

Second-Level Appeal

If you are unsatisfied with the decision of the Third Party Administrator or Wellmark (regarding medical claims only), you may request a second-level appeal with the Appeals Committee of the Board of Trustees of the Fund. The Appeals Committee is not made up of any of the original decision makers or their subordinates. This review will be conducted without regard to the original decision.

In deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, the Appeals Committee may consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. You may request in writing identification of the medical or vocational expert whose advice was obtained on behalf of the plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

You have a period of 30 days after you receive the internal appeal decision to appeal that decision, in writing, and by sending the request to:

Eastern Iowa Fringe Benefit Funds, Inc.
Five Rivers Carpenters District Council Health and Welfare Fund
1831 – 16th Ave SW
Cedar Rapids, IA 52404

Eastern Iowa Fringe Benefit Funds, Inc. will forward your appeal on to the Appeals Committee of the Board of Trustees. All documentation you previously provided to the TPA in the Internal Appeal step will also be forwarded to the Appeals Committee for their review and consideration. The decision on the second-level appeal will be provided to you in writing. Most appeal requests will be determined within 30 days and all appeal requests will be determined within 60 days, unless special circumstances require an extension of time for processing. Written notice of the extension shall be furnished to you prior to the termination of the 30 days.

Expedited Second-Level Appeal Review

A claimant can request an expedited second-level review if there is serious jeopardy to the life or health of the claimant.

The Preliminary Review process needs to be done immediately and the external review process needs to be done with in 48 to 72 hours after the Appeals Committee receives the request.

Appeal to the Federal District Court

If you are dissatisfied with the Appeal Committee's decision, you can bring a civil action under section 502 of ERISA in the United States District Court for the Northern District of Iowa (Cedar Rapids) in support of your position regarding the claim that was denied and against the Fund for denying your claim. Such suit must be brought within 180 days from the date you were informed of the Appeal Committee's decision to deny your second-level appeal.

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

THE HRA IS NOT GUARANTEED BY PENSION BENEFIT GUARANTY CORPORATION

The Pension Benefit Guaranty Corporation (PBGC) is an entity established under ERISA to ensure payment of certain pension benefits. The HRA is part of the Five Rivers Carpenters District Council Health and Welfare Fund, which is not one of the types of plans that the PBGC covers.

COORDINATION OF BENEFITS

COORDINATION OF THE BENEFIT PLANS

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

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

Benefit Plan

This provision will coordinate the medical and dental benefits of a benefit plan. The term benefit plan means this Plan or any one of the following plans:

1. Group or group-type plans, including franchise or blanket benefit plans.
2. Blue Cross and Blue Shield group plans.
3. Group practice and other group prepayment plans.
4. Federal government plans or programs. This includes Medicare.
5. Other plans required or provided by law. This does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination.
6. No Fault Auto Insurance, by whatever name it is called, when not prohibited by law.

Allowable Charge

For a charge to be allowable it must be a Usual, Customary and Reasonable Charge and at least part of it must be covered under this Plan.

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

In the case of service type Plans where services are provided as benefits, the reasonable cash value of each service will be the allowable charge.

Automobile Limitations, Homeowner's or Other Liability Insurance

When medical payments are available under vehicle insurance, homeowner's or other liability insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle Plan deductibles. This Plan shall always be considered the secondary carrier regardless of the individual's election under PIP (personal injury protection) coverage with the auto carrier, homeowner's or other liability insurance.

Benefit Plan Payment Order

When two or more plans provide benefits for the same allowable charge, benefit payment will follow these rules.

1. Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.

2. Plans with a coordination provision will pay their benefits up to the Allowable Charge:

    a. The benefits of the plan which covers the person directly (that is, as an employee, member or subscriber) ("Plan A") are determined before those of the Plan which covers the person as a dependent ("Plan B").

    b. The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid-off or Retired Employee. The benefits of a benefit plan which covers a person as a Dependent of an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a Dependent of a laid off or Retired Employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

    c. The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired or a Dependent of an Employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.

    d. When a child is covered as a Dependent and the parents are not separated or divorced, these rules will apply:

        (i) The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;

        (ii) If both parents have the same birthday, the benefits of the benefit plan which has covered the patient for the longer time are determined before those of the benefit plan which covers the other parent.

    e. When a child's parents are divorced or legally separated, these rules will apply:

        (i) This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.

        (ii) This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the child as a Dependent will be considered next. The benefit plan of the parent without custody will be considered last.

        (iii) This rule will be in place of items (i) and (ii) above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a Dependent.

        (iv) If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are not separated or divorced.

        (v) For parents who were never married to each other, the rules apply as set out above as long as paternity has been established.

    f. If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of allowable charges when paying secondary.

3. Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare is to be the primary payor, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of whether or not the person was enrolled under both of these parts.

4. If a Plan Participant is under a disability extension from a previous benefit Plan, that benefit Plan will pay first and this Plan will pay second.

Claims Determination Period

Benefits will be coordinated on a Calendar Year basis. This is called the claims determination period.

Right to Receive or Release Necessary Information

To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Covered Person will give this Plan the information it asks for about other plans and their payment of allowable charges.

Facility of Payment

This Plan may repay other plans for benefits paid that the Plan Administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

Right of Recovery

This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid from the other benefit plan or the Covered Person. That repayment will count as a valid payment under the other benefit plan. Further, this Plan may pay benefits that are later found to be greater than the allowable charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

SUBROGATION AND/OR ASSIGNMENT

The Fund has enacted a subrogation and/or assignment policy. This means that if a Participant or a Participant's Dependent incurs an injury or illness which is caused in whole or in part by a Third Party such injury or illness, in whole or in part, are not eligible for Fund benefits, claims or payments. The Fund may advance expenses for such Third Party induced or caused illness or injury, in whole or in part, if the Participant (and/or the Participant's beneficiary, if applicable): 1) Execute (sign) a Subrogation and/or Assignment form as approved by the Joint Board of Trustees; 2) Cause their attorney(s) to sign such form; and 3) Delivers such executed (signed) form to the Plan's Third Party Administrator.

> *Thereafter, the Fund may pay benefits as determined by the Plan, but not in excess of that set forth in the Fund's schedule of benefits and in return will require the Participant (or Dependent, if applicable) to pay first to the Fund from any proceeds paid by the Third Party or any other entity on behalf of the Third Party, such amounts as were paid by the Fund on behalf of the Participant and/or Dependent (if applicable) for Fund benefits paid as a result of the injuries or illness caused in whole or in part by the action of the Third Party.*

Payments to the Fund are a first priority and must be made before Participant and/or Participant's beneficiary agent, attorney or other acting for them or in their stead, receives any money or other miniment of value from the Third Party, their insurers or others representing or acting in their behalf.

Failure of the Fund to receive all or part of such moneys or the other miniment of value due the Fund, shall give the Fund the right to recoup same from the Participant and or Participant's beneficiary, including but not by way of limitation or election of remedy: 1) The right to bring a legal or equitable action for payment of such funds; 2) Reduction of Participant's DB and HRA accounts to the extent of payments made by the Fund; or 3) Withholding from Participant and/or Participant's beneficiary, future Fund benefits to the extent of such amounts unpaid to the Fund.

By virtue of the Assignment, the Fund reserves the right to institute action in the name of the Participant and/or Participant's beneficiary against such Third Parties or to intervene in Participants' action against such Third Parties to recover Funds expended by the Fund on behalf of Participant or Participant's beneficiary with respect to injuries or illness caused in whole or in part by such Third Party. If the Fund institutes such action, Participant and Participant's beneficiary shall cooperate with the Fund's representatives in the prosecution of such claim. Failure of Participant or Participant's beneficiary to so cooperate will cause Participant or Participant's beneficiary to be ineligible for future Fund benefits to the extent of the benefit costs paid out by the Fund as a result of the actions in whole or in part of the Third Party.

Participant or Participant's beneficiary will not be responsible to the Fund for Fund expenses in the form of benefits received over and above those occasioned by the actions of the Third Party. For purposes of the subrogation and assignment policy, the term "Third Party" shall include the Participant's or the beneficiary(s) of Participant, uninsured and/or underinsured vehicle insurance, homeowner insurance, public liability insurance or any other insurance which would pay all or part of the benefit **costs paid by the fund.**

The Covered Person:

1. automatically assigns to the Plan his or her rights against any Third Party or insurer when this provision applies; and

2. must repay to the Plan the benefits paid on his or her behalf out of the Recovery made from the Third Party or insurer.

Amount Subject to Subrogation or Refund

The Covered Person agrees to recognize the Plan's right to Subrogation and reimbursement. These rights provide the Plan with a 100%, first dollar priority over any and all Recoveries and funds paid by a Third Party to a Covered Person relative to the Injury or Sickness, including a priority over any claim for non-medical or dental charges, attorney fees, or other costs and expenses. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any and all rights the Covered Person may have to recover payments from any Responsible Third Party. Further, accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan the Covered Person's Third Party Claims.

Notwithstanding its priority to funds, the Plan's Subrogation and Refund rights, as well as the rights assigned to it, are limited to the extent to which the Plan has made, or will make, payments for medical or dental charges as well as any costs and fees associated with the enforcement of its rights under the Plan. The Plan reserves the right to be reimbursed for its court costs and attorneys' fees if the Plan needs to file suit in order to Recover payment for medical or dental expenses from the Covered Person. Also, the Plan's right to Subrogation still applies if the Recovery received by the Covered Person is less than the claimed damage, and, as a result, the claimant is not made whole.

When a right of Recovery exists, the Covered Person will execute and deliver all required instruments and papers as well as doing whatever else is needed to secure the Plan's right of Subrogation as a condition to having the Plan make payments. In addition, the Covered Person will do nothing to prejudice the right of the Plan to Subrogate.

Conditions Precedent to Coverage

The Plan shall have no obligation whatsoever to pay medical or dental benefits to a Covered Person if a Covered Person refuses to cooperate with the Plan's reimbursement and Subrogation rights or refuses to execute and deliver such papers as the Plan may require in furtherance of its reimbursement and Subrogation rights. Further, in the event the Covered Person is a minor, the Plan shall have no obligation to pay any medical or dental benefits incurred on account of Injury or Sickness caused by a responsible Third Party until after the Covered Person or his/her authorized legal representative obtains valid court recognition and approval of the Plan's 100%, first dollar reimbursement and Subrogation rights on all Recoveries, as well as approval for the execution of any papers necessary for the enforcement thereof, as described herein.

Defined Terms

"Covered Person" means anyone covered under the Plan, including minor dependents.

"Recover," "Recovered," "Recovery" or "Recoveries" means all monies paid to the Covered Person by way of judgment, settlement, or otherwise to compensate for all losses caused by the Injury or Sickness, whether or not said losses reflect medical or dental charges covered by the Plan. "Recoveries" further includes, but is not limited to, recoveries for medical or dental expenses, attorneys' fees, costs and expenses, pain and suffering, loss of consortium, wrongful death, lost wages and any other recovery of any form of damages or compensation whatsoever.

"Refund" means repayment to the Plan for medical or dental benefits that it has paid toward care and treatment of the Injury or Sickness.

"Subrogation" means the Plan's right to pursue and place a lien upon the Covered Person's claims for medical or dental charges against the other person.

"Third Party" means any Third Party including another person or a business entity.

Recovery from Another Plan under Which the Covered Person is Covered

This right of Refund also applies when a Covered Person recovers under an uninsured or underinsured motorist plan (which will be treated as Third Party coverage when reimbursement or Subrogation is in order), homeowner's plan, renter's plan, medical malpractice plan or any liability plan.

Rights of Plan Administrator

The Plan Administrator has a right to request reports on and approve of all settlements.

COBRA CONTINUATION OPTIONS

A federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), requires that most employers sponsoring a group health plan ("Plan") offer Employees and their families covered under their health plan the opportunity for a temporary extension of health coverage (called "COBRA continuation coverage") in certain instances where coverage under the Plan would otherwise end. This notice is intended to inform Plan Participants and beneficiaries, in summary fashion, of the rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Third-Party Administrator to Plan Participants who become Qualified Beneficiaries under COBRA.

Note: Special COBRA rights apply to employees who have been terminated or experienced a reduction of hours and who qualify for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 1974. These employees must have made petitions for certification to apply for TAA on or after November 4, 2002.

The employees, if they do not already have COBRA coverage, are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members, but only within a limited period of 60 days or less and only during the six months immediately after their group health plan coverage ended.

Any employee who qualifies or may qualify for assistance under this special provision should contact his or her Third-Party Administrator for further information.

WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is group health plan coverage that an employer must offer to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries") at group rates for up to a statutory-mandated maximum period of time or until they become ineligible for COBRA continuation coverage, whichever occurs first. The right to COBRA continuation coverage is triggered by the occurrence of one of certain enumerated events that result in the loss of coverage under the terms of the employer's Plan (the "Qualifying Event"). The coverage must be identical to the Plan coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

WHO IS A QUALIFIED BENEFICIARY?

In general, a Qualified Beneficiary is:

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

b. Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage. If, however, an individual is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual

will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

c. A covered Employee who retired on or before the date of substantial elimination of Plan coverage which is the result of a bankruptcy proceeding under Title 11 of the U.S. Code with respect to the Employer, as is the Spouse, surviving Spouse or Dependent child of such a covered Employee if, on the day before the bankruptcy Qualifying Event, the Spouse, surviving Spouse or Dependent child was a beneficiary under the Plan.

The term "covered Employee" includes not only common-law employees (whether part-time or full-time) but also any individual who is provided coverage under the Plan due to his or her performance of services for the employer sponsoring the Plan (e.g., self-employed individuals, independent contractor, or corporate director).

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

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

WHAT IS A QUALIFYING EVENT?

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

a. The death of a covered Employee.

b. The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.

c. The divorce or legal separation of a covered Employee from the Employee's Spouse.

d. A covered Employee's enrollment in the Medicare program.

e. A Dependent child's ceasing to satisfy the Plan's requirements for a Dependent child (e.g., attainment of the maximum age for dependency under the Plan).

f. A proceeding in bankruptcy under Title 11 of the U.S. Code with respect to an Employer from whose employment a covered Employee retired at any time.

If the Qualifying Event causes the covered Employee, or the Spouse or a Dependent child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event (or in the case of the bankruptcy of the Employer, any substantial elimination of coverage under the Plan occurring within 12 months before or after the date the bankruptcy proceeding commences), the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of the COBRA law are also met. Any increase in contribution that must be paid by a covered Employee, or the Spouse, or a Dependent child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

WHAT IS THE ELECTION PERIOD AND HOW LONG MUST IT LAST?

An election period is the time period within which the Qualified Beneficiary can elect COBRA continuation coverage under the Employer's Plan. A Plan can condition availability of COBRA continuation coverage upon the timely election of such coverage. An election of COBRA continuation coverage is a timely election if it is made during the election period. The election period must begin not later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and must not end before the date that is 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage.

IS A COVERED EMPLOYEE OR QUALIFIED BENEFICIARY RESPONSIBLE FOR INFORMING THE THIRD-PARTY ADMINISTRATOR OF THE OCCURRENCE OF A QUALIFYING EVENT?

In general, the Third-Party Administrator must determine when a Qualifying Event has occurred. However, each covered Employee or Qualified Beneficiary is responsible for notifying the Third-Party Administrator of the occurrence of a Qualifying Event that is:

a. A Dependent child ceasing to be a Dependent child under the generally applicable requirements of the Plan.

b. The divorce or legal separation of the covered Employee.

The Plan is not required to offer the Qualified Beneficiary an opportunity to elect COBRA continuation coverage if the notice is not provided to the Third-Party Administrator within 60 days after the later of: the date of the Qualifying Event, or the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event.

IS A WAIVER BEFORE THE END OF THE ELECTION PERIOD EFFECTIVE TO END A QUALIFIED BENEFICIARY'S ELECTION RIGHTS?

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Third-Party Administrator, as applicable.

WHEN MAY A QUALIFIED BENEFICIARY'S COBRA CONTINUATION COVERAGE BE TERMINATED?

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

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

b. The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.

c. The date upon which the Employer ceases to provide any group health plan (including successor plans) to any Employee.

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

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

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

c. (i) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

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

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

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

coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

WHAT ARE THE MAXIMUM COVERAGE PERIODS FOR COBRA CONTINUATION COVERAGE?

The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below.

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

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

   (i) 36 months after the date the covered Employee becomes enrolled in the Medicare program; or

   (ii) 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.

c. In the case of a bankruptcy Qualifying Event, the maximum coverage period for a Qualified Beneficiary who is the retired covered Employee ends on the date of the retired covered Employee's death. The maximum coverage period for a Qualified Beneficiary who is the Spouse, surviving Spouse or Dependent child of the retired covered Employee ends on the earlier of the date of the Qualified Beneficiary's death or the date that is 36 months after the death of the retired covered Employee.

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

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

UNDER WHAT CIRCUMSTANCES CAN THE MAXIMUM COVERAGE PERIOD BE EXPANDED?

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

HOW DOES A QUALIFIED BENEFICIARY BECOME ENTITLED TO A DISABILITY EXTENSION?

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

CAN A PLAN REQUIRE PAYMENT FOR COBRA CONTINUATION COVERAGE?

Yes. For any period of COBRA continuation coverage, a Plan can require the payment of an amount that does not exceed 102% of the applicable premium except the Plan may require the payment of an amount that does not exceed 150% of the applicable premium for any period of COBRA continuation coverage covering a disabled qualified beneficiary that would not be required to be made available in the absence of a disability extension. A group health plan can terminate a qualified beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made to the Plan with respect to that qualified beneficiary.

MUST THE PLAN ALLOW PAYMENT FOR COBRA CONTINUATION COVERAGE TO BE MADE IN MONTHLY INSTALLMENTS?

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

WHAT IS TIMELY PAYMENT FOR PAYMENT FOR COBRA CONTINUATION COVERAGE?

Timely Payment means payment that is made to the Plan by the date that is 30 days after the first day of that period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered Employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

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

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of $50.00 or 10% of the required amount.

RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR

The Plan Administrator of the Five Rivers Carpenters District Council Health and Welfare Fund is the Joint Board of Trustees of the Five Rivers Carpenters District Council Health and Welfare Fund, also called the Plan Sponsor. The Plan is to be administered by the Plan Administrator in accordance with the provisions of ERISA.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the expressed intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

Service of legal process may be made upon the Plan Administrator.

DUTIES OF THE PLAN ADMINISTRATOR

1. To administer the Plan in accordance with its terms.
2. To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.
3. To decide disputes which may arise relative to a Plan Participant's rights.
4. To prescribe procedures for filing a claim for benefits and to review claim denials.
5. To keep and maintain the Plan documents and all other records pertaining to the Plan.
6. To appoint a Claims Administrator to pay claims.
7. To perform all necessary reporting as required by ERISA.
8. To establish and communicate procedures to determine whether a medical child support order is qualified under ERISA Sec. 609.
9. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

PLAN ADMINISTRATOR COMPENSATION

The Joint Board of Trustees serves **without** compensation except lost time of hourly Trustees is reimbursed; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

FIDUCIARY

A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets, renders investment advice to the Plan or has discretionary authority or responsibility in the administration of the Plan.

FIDUCIARY DUTIES

A fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to the Members and their Dependent(s), and defraying reasonable expenses incurred of administering the Plan. These are duties which must be carried out:

1. with care, skill, prudence and diligence under the given circumstances that a prudent person; acting in a like capacity and familiar with such matters, would use in a similar situation;

2. by diversifying the investments of the Plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and

3. in accordance with the Plan documents to the extent that they agree with ERISA.

THE NAMED FIDUCIARY

A "named fiduciary" is the Joint Board of Trustees of the Five Rivers Carpenters District Council Health and Welfare Fund. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary shall not be liable for any act or omission of such person unless either:

1. the named fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment or the procedures; or

2. the named fiduciary breached its fiduciary responsibility under Section 405(a) of ERISA.

THIRD-PARTY ADMINISTRATOR/CLAIMS ADMINISTRATOR IS NOT A FIDUCIARY

A Third-Party Administrator/Claims Administrator is **not** a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

PROCEDURE FOR RECEIPT OF QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSO)

Upon receipt of a Qualified Medical Child Support Order (QMCSO), the Claims Administrator:

1. Will notify the Member and alternate recipient (i.e., the child or the child’s representative) of the Plan’s receipt of the order and the Plan’s procedures for determining whether the order is qualified;

2. Will send a copy of the order to Fund Counsel for a determination of whether the order is qualified, this shall be done within a reasonable period;

3. Will notify the Member and each alternative recipient of the determination; and

4. If the order is qualified, will administer the provision of benefits under such orders.

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

For Member and Dependent Coverage: Funding is derived solely from the funds of contributing Employers and earnings from same.

Benefits are paid directly from the Plan through the Third-Party Administrator/Claims Administrator.

CLERICAL ERROR

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, if it is requested, the amount of overpayment will be deducted from future benefits payable or their DB and or HRA accounts.

INTERPRETATION OF THE PLAN

Any interpretation of the Plan's provisions rests with the Joint Board of Trustees, the Plan Administrator. No employer or union, nor any representative of any employer or union, is authorized to interpret this Plan on behalf of the Joint Board nor can an employer or union act as an agent of the Joint Board of Trustees.

However, the Joint Board of Trustees has authorized the Third-Party Administrator/Claims Administrator to handle routine requests from participants regarding eligibility rules, benefits, and claims procedures, but, if there are any questions involving interpretation of any Plan provision, the Third-Party Administrator/Claims Administrator will ask the Board of Trustees, the Plan Administrator, for a final determination.

AMENDING AND TERMINATING THE PLAN

If the Plan is terminated, the rights of the Plan Participants are limited to expenses incurred before termination.

The Board of Trustees intends to maintain this Plan indefinitely; however, it reserves the right, at any time, to amend, suspend or terminate the Plan in part. This includes amending the benefits under the Plan.

CERTAIN PLAN PARTICIPANTS RIGHTS UNDER ERISA

Plan Participants in this Plan are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA specifies that all Plan Participants shall be entitled to:

Receive information about your plan and benefits.

Examine, without charge, at the Third-Party Administrator's office, and at other specified locations, such as worksites and union halls, all Plan documents and copies of all documents governing the Plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefits Administration.

Obtain, upon written request to the Third-Party Administrator, copies of all Plan documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Third-Party Administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The Third-Party Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue health care coverage for a Plan Participant, Spouse, or other dependents if there is a loss of coverage under the Plan as a result of a qualifying event. Members or dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan or the rules governing COBRA continuation coverage rights.

If a Plan Participant's claim for a benefit is denied or ignored, in whole or in part, the participant has a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps a Plan Participant can take to enforce the above rights. For instance, if a Plan Participant requests a copy of Plan documents or the latest annual report from the Plan and does not receive them within 30 days, he or she may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and to pay the Plan Participant up to $110.00 a day until he or she receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If the Plan Participant has a claim for benefits which is denied or ignored, in whole or in part, the participant may file suit in state or federal court.

In addition, if a Plan Participant disagrees with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, he or she may file suit in federal court.

In addition to creating rights for Plan Participants, ERISA imposes obligations upon the individuals who are responsible for the operation of the Plan. The individuals who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Plan Participants and their beneficiaries. No one, including the Employer, your union or any other person, may fire a Plan Participant or otherwise discriminate against a Plan Participant in any way to prevent the Plan Participant from obtaining benefits under the Plan or from exercising his or her rights under ERISA.

If it should happen that the Plan fiduciaries misuse the Plan's money, or if a Plan Participant is discriminated against for asserting his or her rights, he or she may seek assistance from the U.S. Department of Labor, or may file suit in federal court. The court will decide who should pay court costs and legal fees. If the Plan Participant is successful, the court may order the person sued to pay these costs and fees. If the Plan Participant loses, the court may order him or her to pay these costs and fees, for example, if it finds the claim or suit to be frivolous.

If the Plan Participant has any questions about the Plan, he or she should contact the Third-Party Administrator. If the Plan Participant has any questions about this statement or his or her rights under ERISA or the Health Insurance Portability and Accountability Act (HIPAA), that Plan Participant should contact either the nearest area office of the Employee Benefits Security Administration, U.S. Department of Labor listed in the telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

HIPAA PRIVACY

THIRD-PARTY ADMINISTRATOR'S CERTIFICATION OF COMPLIANCE

Neither the Health Plan nor any business associate servicing the Health Plan will disclose Health Plan Enrollees' Protected Health Information to the Plan Administrator unless the Plan Administrator certifies that the Health Plan's Plan Document has been amended to incorporate this section and agrees to abide by this section.

PURPOSE OF DISCLOSURE TO THIRD-PARTY ADMINISTRATOR

The Health Plan and any business associate servicing the Health Plan will disclose Health Plan Enrollees' Protected Health Information to the Plan Administrator only to permit the Plan Administrator to carry out plan administration functions for the Health Plan not inconsistent with the requirements of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (45 C.R.R. Parts 160-64). Any disclosure to and use by the Plan Administrator of Health Plan Enrollees' Protected Health Information will be subject to and consistent with the provisions of Restrictions of Plan Administrator's Use and Disclosure of Protected Health Information and Adequate Separation Between the Plan Administrator and the Health Plan of this section.

Neither the Health Plan nor any business associate servicing the Health Plan will disclose Health Plan Enrollees' Protected Health Information to the Plan Administrator unless the disclosures are explained in the Notice of Privacy Practices distributed to the Health Plan Enrollees'.

RESTRICTIONS ON PLAN ADMINISTRATOR'S USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The Plan Administrator will neither use nor further disclose Health Plan Enrollees' Protected Health Information, except as permitted or required by the Health Plan's Plan Document, as amended, or required by law.

The Plan Administrator will ensure that any agent, including any subcontractor, to whom it provides Health Plan Enrollees' Protected Health Information agrees to the restrictions and conditions of the Health Plan's Plan Documents, including this section, with respect to Health Plan Enrollees' Protected Health Information.

The Plan Administrator will not use or disclose Health Plan Enrollees' Protected Health Information for employment-related actions or decisions or in connection with any other benefits or employee benefit plan of the Plan Administrator.

The Plan Administrator will report to the Health Plan any use or disclosure of Health Plan Enrollees' Protected Health Information that is inconsistent with the uses and disclosures allowed under this section promptly upon learning of such inconsistent use or disclosure.

The Plan Administrator will make Protected Health Information available to the Health Plan Enrollee who is the subject of the information in accordance with 45 Code of Federal Regulations §164.524.

The Plan Administrator will make Health Plan Enrollees' Protected Health Information available for amendment, and will on notice amend Plan Enrollees' Protected Health Information, in accordance with 45 Code of Federal Regulations § 164.526.

The Plan Administrator will track disclosures it may make of Health Plan Enrollees' Protected Health Information so that it can make available the information required for the Health Plan to provide an accounting of disclosures in accordance with 45 Code of Federal Regulations §164.528.

The Plan Administrator will make its internal practices, books, and records, relating to its use and disclosure of Health Plan Enrollees' Protected Health Information, to the Health Plan and to the U.S. Department of Health and Human Services to determine compliance with 45 Code of Federal Regulations Parts 160-64.

The Plan Administrator will, if feasible, return or destroy all Health Plan Enrollee Protected Health Information, in whatever form or medium, received from the Health Plan when the Health Plan Enrollees' Protected Health Information is no longer needed for the plan administration functions for which the disclosure was made. If it is not feasible to return or destroy all Health Plan Enrollee Protected Health Information, the Plan Administrator will limit the use or disclosure of any Health Plan Enrollee Protected Health Information it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.

ADEQUATE SEPARATION BETWEEN THE PLAN ADMINISTRATOR AND THE HEALTH PLAN

The following classes of employees or service providers under the control of the Plan Administrator may be given access to Health Plan Enrollees' Protected Health Information received from the Health Plan:

Eastern Iowa Fringe Benefit Funds, Inc. (claims adjudicators/processors, claims reviewers, persons who determine or handle eligibility information, supervisors, claims payors)
Wellmark Blue Cross and Blue Shield of Iowa (re-pricing, medical claims adjudicators/processors, claims reviewers, claims payors)
Innovative Software Solutions, Inc. (software maintenance)
OptumRx (formerly known as Catamaran) (prescription drug plan)
LWBJ, LLP (auditor)
Day Rettig Martin, P.C. (attorneys)
Foster & Foster (insurance consultant)

This list includes every class of employees or service providers under the control of the Plan Administrator who may receive Health Plan Enrollees' Protected Health Information relating to payment under, health care operations of, or other matters pertaining to the Health Plan in the ordinary course of business.

The classes of employees or service providers identified in the list above will have access to Health Plan Enrollees' Protected Health Information only to perform the plan administration functions that the Plan Administrator provides for the Health Plan.

The classes of employees or service providers identities above in the list of this section will be subject to disciplinary action and sanctions, including termination of employment or affiliation with the Plan Administrator, for any use or disclosure of Health Plan Enrollees' Protected Health Information in breach or violation of or noncompliance with the provisions of this section to the Health Plan's Plan Document.

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

The Plan is a self-funded group health and disability Plan and the claims administration is provided through a Third Party Claims Administrator, Eastern Iowa Fringe Benefit Funds, Inc. The medical claims administration is provided

through Wellmark Blue Cross and Blue Shield of Iowa. The funding for the benefits is derived from the funds of the Employer. The Plan is self-insured.

PLAN NAME:

Five Rivers Carpenters District Council Health and Welfare Fund

PLAN NUMBER:

501

TAX ID NUMBER:

42-6149936

PLAN EFFECTIVE DATE:

January 1, 2017

PLAN YEAR ENDS:

December 31

NAME AND TITLE OF EACH TRUSTEE

The Trustees of this Fund are:

Management Trustees	**Union Trustees**
John Calacci Calacci Construction P.O. Box 1906 Iowa City, IA 52244-1906 Phone: 319-354-7000	Royce Peterson Carpenters Local 1260 820 12th Avenue Coralville, IA 52241 Phone: 319-338-1638
Jim Unzeitig Unzeitig Construction 1619 F Avenue NE Cedar Rapids, IA 52402 Phone: 319-362-3221	Patrick Loeffler Carpenters Local 308 350 Waconia Ct SW Cedar Rapids, IA 52404 Phone: 319-560-3554 Phone: 319-363-0279
Mike Novy 2408 Cimarron Drive Marion, IA 52302 Phone: 319-533-5500	Robb Nelson Deputy General Counsel 700 Olive Street Saint Paul, MN 55130 Phone: 651-341-4440
Alternate: Dave Unzeitig Unzeitig Construction 1619 F Avenue NE Cedar Rapids, IA 52402 Phone: 319-362-3221	Alternate: Bruce Werning Chicago Regional Council 1503 First Ave., Suite C Rock Falls, IL 61071 Phone: 815-626-2177

A complete list of the employers and employee organizations sponsoring the Plan may be obtained by participants upon written request to the Plan Administrator and is available for examination by participants. Participants may receive from the Plan Administrator, upon written request, information as to whether a particular employer or employee organization is a sponsor of the plan and, if the employer or employee is a plan sponsor, the sponsor's address.

THE COLLECTIVE BARGAINING AGREEMENT

The Fund is established and maintained under the terms of a Collective Bargaining Agreement. This agreement sets forth in the conditions under which participating Employers are required to contribute to the Fund. A copy of the collective bargaining agreement may be obtained upon written request to your local union hall and is available for examination by participants and beneficiaries.

PLAN ADMINISTRATOR

Joint Board of Trustees
c/o Eastern Iowa Fringe Benefit Funds, Inc
1831 – 16th Avenue SW
Cedar Rapids, IA 52404
(319) 366-3623

NAMED FIDUCIARY

Board of Trustees of the Five Rivers Carpenters District Council Health and Welfare Fund
c/o Eastern Iowa Fringe Benefit Funds, Inc.
1831 – 16th Avenue SW
Cedar Rapids, IA 52404
(319) 366-3623

AGENT FOR SERVICE OF LEGAL PROCESS

Jennifer E. Germaine, Esq. Day Rettig Martin, P.C.
Five Rivers Carpenters District Council Health and Welfare Fund
150 First Ave. N.E., Suite 415
P.O. Box 2877
Cedar Rapids, IA 52406-2877

Service of legal process may be made upon a plan trustee or the plan administrator.

THIRD PARTY ADMINISTRATOR

Eastern Iowa Fringe Benefit Funds, Inc.
1831 – 16th Ave SW
Cedar Rapids, IA 52404
(800) 847-0113 or (319) 366-3623

CUSTODIAL BANK

Cedar Rapids Bank & Trust
500 1st Avenue NE #100
Cedar Rapids, IA 52401

SOURCE OF TRUST FUND INCOME:

Sources of Trust Fund income include Employer contributions, Employee self-payment of contributions, investment earnings, and may include rebates from the Pharmacy Benefit Manager. All Employer contributions are paid to the Trust Fund subject to provisions in the collective bargaining or non-bargaining participation agreements between the Union and an Employer Association of those Employers who are not members of or represented by an Association but who have executed an individual collective bargaining agreement with the Local Union. Participants may obtain a copy of the collective bargaining agreement upon written request to the Third-Party Administrator and is available for examination by participants.

The agreement specifies the amount of contributions, due date of Employer contributions, type of work for which contributions are payable and the geographic area covered by the labor contract.

NONASSIGNMENT

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

GOVERNING LAW

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

LEGAL ACTION

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

You shall not bring any legal or equitable action against us because of a claim under this 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.

HEATHCARE DEFINITIONS AND OTHER TERMS OF THE PLAN

The following terms have special meanings and when used in this Plan will be capitalized.

Active Work and Actively at Work means performing an employee's regular duties for a full work day under the applicable Collective Bargaining Agreement.

Allowable Medical Expenses means a medical expense "incurred" at the time the medical care or service is provided, not when the individual incurring the expense is formally billed for, is charged for, or pays for the medical care. Allowable Medical Care Expenses incurred before you become covered by the Plan are **not** eligible. Medical Care Expenses incurred before January 1, 2017 are also **not** eligible. However, an Allowable Medical Care Expense incurred during one calendar year may be paid during a later calendar year, provided you participated in the Plan during both calendar years.

Allowable Medical Care Expenses are all expenses incurred on or after January 1, 2012 by you, your spouse, or your Eligible Dependents that are recognized as reimbursable medical expenses under Section 213(d) of the Internal Revenue Code and to IRS Publication 502 titled, "Medical and Dental Expenses." Catalog Number 15002Q. You can order the publication by calling (800) TAX-Form or see it online at www.irsgov/pub/irs-p502.pdf. For tax advice please seek the services of a competent professional.

Examples of Medical Care Expenses incurred on or After January 1, 2012 Eligible for Reimbursement Under the Five Rivers Carpenters District Council Health and Welfare Fund Health Reimbursement Arrangement are:

• Abdominal supports • Acupuncture • Alcoholism treatment • Ambulance • Anesthetist • Arch supports • Artificial limbs • Birth control pills (by prescription) • Blood tests • Blood transfusions • Braces • Cardiographs • Christian Science practitioner • Contact lenses • Contraception devices (by prescription) • Convalescent home (for medical treatment only	• Drug addition therapy • Eye glasses • Guide dog • Gum treatment • Medical amounts in excess of plan maximums • Medical co-pays • Medical deductibles • Psychoanalyst • Psychologist • Psychotherapy • Radium therapy • Registered nurse • Special school costs for the handicapped • Spinal fluid test • Splints • Sterilization

• Crutches • Dental amounts in excess of plan maximum • Dental co-pays • Dental deductibles • Dental treatment • Dental x-rays • Dentures • Dermatologist • Diagnostic fees • Diathermy	• Surgeon • Therapy • Ultraviolet ray treatment • Vaccines • Vasectomy • Vision care • Vitamins (if prescribed) • Wheelchair • X-rays

Examples continued:

Eligible over-the-counter drugs

- Insulin

Please note that reimbursement for over-the-counter drugs that could be eligible require a prescription from a physician.

Eye Surgery
You can include in medical expenses the amount you pay for eye surgery to treat defective vision, such as laser eye surgery or radial keratotomy.

Dental Treatment
You can include in medical expenses the amount you pay for the prevention and alleviation of dental disease above the Maximum Benefit in the Schedule of Benefits. Preventive treatment includes the services of a dental hygienist or dentist for such procedures as teeth cleaning, the application of sealants, and fluoride treatments to prevent tooth decay. Treatment to alleviate dental disease include services of a dentist for procedures such as X-rays, fillings, braces, extractions, dentures, and other dental ailments. Note: Teeth Whitening Is Not Includable.

Stop Smoking Programs
You can include in medical expenses amounts you pay for a program to stop smoking. However, you cannot include in medical expenses amounts you pay for drugs that do not require a prescription, such as nicotine gum or patches, that are designed to help stop smoking.

Weight-Loss Program
You can include in medical expenses amounts you pay to lose weight if it is a treatment for a specific disease diagnosed by a physician (such as obesity, hypertension or heart disease). This includes fees you pay for membership in a weight reduction group as well as fees for attendance at periodic meetings. You cannot include membership dues in a gym, health club or spa as medical expenses, but you can include separate fees charged there for weight loss activities.

You cannot include the cost of diet food or beverages in medical expenses because the diet food and beverages substitute for what is normally consumed to satisfy nutritional needs. You can include the cost of special food in medical expenses only if:

1. The food does not satisfy normal nutritional needs,
2. The food alleviates or treats an illness, and
3. The need for the food is substantiated by a physician.

The amount you can include in medical expenses is limited to the amount by which the cost of the special food exceeds the cost of a normal diet.

Benefit Descriptions. Explains when the benefit applies and the types of charges covered.

Calendar Month means any of the twelve named months of the year commencing with the first day of such month.

Calendar Quarter - please refer to coverage quarter.

Calendar Year means January 1st through December 31st of the same year.

Claim Provisions. Explains the rules for filing claims and the claim appeal process.

COBRA Continuation Options. Explains when a person's coverage under the Plan ceases and the continuation options which are available
Cosmetic Dentistry means dentally unnecessary procedures.

Cosmetic Service means any procedure performed primarily:

1. to improve physical appearance; or

2. to treat a mental or nervous disorder through a change in bodily form; or

3. to change or restore bodily form without correcting or materially improving a bodily function.

Coverage Quarter means a period of three consecutive calendar months commencing on January 1, April 1, July 1, or October 1.

Covered Employer is an Employer participating in the Plan by virtue of being signatory to the Collective Bargaining Agreement with Five Rivers Carpenters District Council Health and Welfare Eligibility Rules or has signed an Acceptance of Trust agreement or Participation Agreement.

Covered Employment means any employee working under the Collective Bargaining Agreement or a Participation Agreement as an employee of a contributing employer.

Covered Person is an Employee or Dependent who is covered under this Plan.

Covered Services means services that are eligible for consideration to be paid under this Plan.

Defined Terms. Defines those Plan terms that have a specific meaning.

Dental Hygienist means a person who is currently licensed (if licensing is required in the state) to practice dental hygiene by the governmental authority having jurisdiction over the licensure and practice of dental hygiene in the state of Iowa and who works under the supervision of a Dentist.

Dentist is a person who is properly trained and licensed to practice dentistry and who is practicing within the scope of such license.

Diagnosis is the statement of the medical condition requiring the care of a physician.

Dollar Bank (DB) is an individual notional account that receives employer contributions to pay for an individual's Death Benefits, Accidental Death and Dismemberment Benefits and Short Term Disability Benefits before the balance in the account is transferred to the employee's individual Health Reimbursement Arrangement (HRA) or to pay health care premiums. This is not an account in which the Participant is vested.

Eligible Dependents are as defined on page 14.

Eligibility, Funding, Effective Date and Termination. Explains eligibility for coverage under the Plan, funding of the Plan and when the coverage takes effect and terminates.

Eligibility Rules shall apply to Active Employees and their Dependents, Totally and Permanently Disabled Employees and their Dependents, and Self-Pay Employees and their Dependents and Retirees and their Dependents.

Employee, Participant or Eligible Member means any person who: (1) is working within the jurisdiction of and is covered under the terms of the Collective Bargaining Agreement or Non-Bargaining Participation Agreement entered into between the Union and the Employer, and (2) is eligible for benefits as set forth in the Five Rivers Carpenters District Council Health and Welfare Eligibility Rules.

Employer or Contributing Employer means any association or individual employer who has duly executed a collective bargaining agreement with the Union and is thereby required to make contributions to this Fund on behalf of its Employees. Any employer not presently party to such collective bargaining agreement who satisfies the requirements for participation as established by the Trustees and agrees to be bound by the Trust Agreement is also included in this definition. The Union is also considered an employer for purposes of contributions on behalf of its employees only.

Enrollment Date is the first day of coverage.

ERISA is the Employee Retirement Income Security Act of 1974, as amended.

ERISA Information. Explains the Plan's structure and the Participants' rights under the Plan

Expense Incurred includes only those charges made for services and supplies which are reasonably priced and reasonably necessary in the light of the injury or sickness being treated.

Family Unit is the covered Employee and the family members who are covered as Dependents under the Plan.

Health Reimbursement Arrangement (HRA) is an individual notional account to be used to pay health care premiums and other allowable medical expenses, on a tax free basis, as approved the IRS. This is not an account in which the Participant is vested.

Ineligible Medical Expenses means medical expenses or pharmaceuticals that are not considered eligible for reimbursement under the IRS code

Examples of Medical Care Expenses Incurred on or After January 1, 2012 Ineligible for Reimbursement Under the Five Rivers Carpenters District Council Health and Welfare Fund Health Reimbursement Arrangement are.

Medical Care Expense Exclusions

Ineligible medical expenses		
• Advance payment for services to be rendered next year • Athletic club membership • Automobile insurance premium allocable to medical coverage • Boarding school fees • Bottled water • Commuting expenses of a disabled person • Cosmetic surgery and procedures • Cosmetics, hygiene products and similar items • Funeral, cremation or burial expenses	• Health programs offered by resort hotels, health clubs and gyms • Illegal operations and treatments • Illegally procured drugs • Maternity clothes • Penalties for failure to pre-certify according to health plan rules • Premiums for life insurance, income protection, disability, loss of limbs, sight or similar benefits • Scientology counseling • Social activities	• Special foods and beverages • Specially designed car for the handicapped • Swimming pool • Travel for general health improvement • Tuition and travel expenses to send a problem child to a particular school
Ineligible over-the-counter drugs		
• Acne treatments • Allergy medications • Antacids • Antibiotic ointments • Anti-diarrhea medicine • Calamine lotion • Cold medicine • Cosmetics (including face cream and moisturizer) • Cough drops and throat lozenges • Dietary supplements	• Fiber supplements • First aid creams • Herbs • Lip balm (including Chapstick® or Carmex®) • Medicated shampoos and soaps • Motion sickness pills • Nasal sprays • Nicotine medications • Pain relievers • Pedialyte®	• Sleep aids • Sinus medications and nasal sprays • Suppositories and creams for hemorrhoids • Toiletries (including toothpaste) • Vitamins (daily) • Wart removal medication • Weight-loss drugs for general wellbeing

Medical care expenses do not include expenses covered by any other benefit plan. Medical care expenses can only be reimbursed to the extent that you and any other person incurring them were not reimbursed for the expense through other insurance including any other accident or health plan. Medical care expenses do not

include an item that does not constitute “medical care,” as defined under the Internal Revenue Code Section 213(d) (1).

Medically or Dentally Necessary care and treatment is recommended or approved by a Physician or Dentist; is consistent with the patient's condition or accepted standards of good medical and dental practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or provider of medical and dental services; is not conducted for research purposes; and is the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met; merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary.

The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically or Dentally Necessary.

Medicare is the Health Insurance for the Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

No-Fault Auto Insurance is the basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

Optician, Optometrist and Ophthalmologist means any person who is qualified and currently licensed (if licensing is required in the State) to practice each such profession by the appropriate government agency or authority having jurisdiction over the licensure and practice of such a profession, and who is acting within the usual scope of his practice.

Period of Disability Confinement refers to successive periods of disability or Hospital confinement and is considered one (1) continuous disability and period of confinement for the purpose of determining maximum benefit payable unless:

1. The later treatment period is due to causes entirely unrelated to the causes of the prior treatment; or

2. The period of treatments are separated by ninety (90) calendar days; or

3. For an Employee, a return to covered employment for at least two (2) weeks.

Plan means Five Rivers Carpenters District Council Health and Welfare Fund, which is a benefits plan for Plan Participants in the Fund of Five Rivers Carpenters and is described in this document.

Plan Exclusions. Shows what charges are **not** covered.

Plan Participant is any eligible Employee of a contributing contractor.

Plan Year is the 12-month period beginning on either the effective date of the Plan or on the day following the end of the first Plan Year which is a short Plan Year.

Prescription Drug means any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of a Sickness or Injury.

In regard to drugs and drug therapies newly approved by the U.S. Food and Drug Administration (FDA) and available to the consumer market after the Summary Plan Descriptions have been distributed, the Plan reserves the right to:

- extend coverage to medications that have recently met the FDA guidelines;
- assign a unique co-payment or coinsurance to new drugs entering the market;
- limit quantities of new lifestyle type drugs entering the market; and
- add drugs to the exclusion list if the FDA has issued a warning or a recall, voluntary or otherwise, to the consumer market.

Plan participants will receive notices regarding any Plan modifications regarding drugs or therapies at such time that they present a prescription for drugs or drug therapies impacted by modifications to the Plan. Participating pharmacies are charged to communicate any updates or changes to the Plan pharmacy program, which impact a participant.

Qualified Medical Child Support Order (QMCSO) is a judgment, decree or order (including approval of a settlement agreement) issued pursuant to State domestic relations law, including community property law, which creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive benefits for which an Employee or eligible Dependent is entitled under this Plan. A QMCSO must be issued by a court of competent jurisdiction or through administrative process established under state law and carrying the force and effect of law in that state. For such an order to be a QMCSO, it must clearly specify:

1. The name and last known mailing address (if any) of the participant, and the name and mailing address of each Alternate Recipient covered by the order; and

2. Reasonable description of the type of coverage to be provided by the Plan to each such Alternate Recipient, or the manner in which such type of coverage is to be determined; and

3. The period to which such order applies; and

4. The name of this Plan.

Such an order need not be recognized as "qualified" if it requires the Plan to provide any type or form of benefits, or any option, not otherwise provided under the Plan, except to the extent necessary to meet the requirements of a state law relating to medical child support orders, as described in Section 1908 of the Social Security Act, as amended.

An Employee/Alternate beneficiary may obtain a copy of the Fund's procedures regarding a Qualified Medical Child Support Order from the Fund's Third-Party Administrator or legal counsel.

Routine Physical Examination is an examination done by a physician for screening purposes. If no diagnosis or symptoms are presented on a claim form or itemized bill by the physician, the care will be considered routine.

Schedule of Benefits. Provides an outline of the Plan reimbursement formulas as well as payment limits on certain services.

Third-Party Administrator means Eastern Iowa Fringe Benefit Funds, Inc.

Third Party Recovery Provision. Explains the Plan's rights to recover payment of charges when a Covered Person has a claim against another person because of injuries sustained.

Totally Disabled and Total Disability, unless otherwise specifically defined, refer to disability resulting solely from a sickness or accidental bodily injury which prevents an Employee from engaging in **any** occupation or employment for compensation or profit or prevents a Dependent from engaging in substantially all the normal activities of a person of like age and sex in good health **and** the person is eligible for Social Security Disability Benefits. A copy of the Social Security Administration Award Letter is required for proof of total disability.

Trust Agreement means the Agreement and Declaration of Trust establishing the Five Rivers Carpenters District Council Health and Welfare Fund and that instrument as amended from time to time.

Trust Fund or Fund means the Five Rivers Carpenters District Council Health and Welfare Fund.

Trustees mean the Employer Trustees and the Union Trustees, collectively, as selected under the Trust Agreement, and as constituted from time to time in accordance with the provisions of the Trust Agreement.

Union shall mean the geographical jurisdiction of those Local Unions which are signatory to a Collective Bargaining Agreement requiring employer contributions to this Fund.

Usual, Customary and Reasonable Charge (for dental or vision) is determined by **uniform reference standards** as adopted by the Board of Trustees. To be considered reasonable and customary, the charge by any provider for a service must be similar to the charges generally incurred for cases of comparable nature and severity by a physician of similar training and experience in the 520, 522, 523, 524, 527, and 528 zip code geographical areas. Exception to the above would be Participants dependent children who are domiciled in these zip code zones, but attending an accredited school outside the noted zip code zones, or Participants and their dependents who are temporarily absent from eastern Iowa, such as on a trip. The application of the above will be a difficult occasion when the Participant employee is working, temporarily, outside the above zip code zones under` a Collective Bargaining Agreement between an Employer and an affiliate of the United Brotherhood of Carpenters International, because there is no

available work in the above zip code zones. Only under this exception will the Fund pay for covered expenses based upon the usual, customary and reasonable doctor and hospital charges used in the area where the service was performed to the Participant and/or his dependents, otherwise the Fund will pay for the charges not to exceed the UCR rates used for the named zip codes.

The Plan will reimburse the actual charge billed if it is less than the Usual, Customary and Reasonable.

The Plan Administrator has the discretionary authority to decide whether a charge is Usual, Customary and Reasonable.

Attachment 1

Election to become a Retiree under the Five Rivers Carpenters District Council Health and Welfare Fund

I,_____, hereby elect as of _____ ____, 20___ to become a retiree under the Five Rivers Carpenters District Council Health and Welfare Plan, I understand in doing so and by making the following election that the choice of this option can NOT be reversed.

Please initial either Option 1 or Option 2; you can only elect one option.

Option 1 is for you to remain in the Health and Welfare Plan such that you will maintain coverage for the benefits you select on the election form along with the Health Reimbursement Arrangement (HRA) account. You will have your monthly benefit premium paid from the HRA account when due, and if this account is not sufficient to pay the monthly benefit premium, then you will have the opportunity to be a self pay member, as in accordance with the plan document. By electing this option you are requesting the administrator to transfer any Dollar Bank (DB) account assets to your HRA account effective as of the end of the quarter in which you retire. Remember if you elect this option you can NOT reverse your decision at a later date _____, or

Option 2 is for you to elect NOT to remain eligible for benefits under the Five River Carpenters Health and Welfare Plan with the exception of using the Health Reimbursement Arrangement (HRA) account to reimburse you and or your dependents for eligible medical expenses as allowed by the IRS rules and regulations. By electing this option you are requesting the administrator to transfer any Dollar Bank (DB) account assets to your HRA account effective as of the end of the quarter in which you retire. Remember if you elect this option you can NOT reverse your decision at a later date and you will not have the opportunity to have medical coverage under this plan to carry you to Medicare eligibility (currently age 65). _____

Signed_____

Dated_____ ____, ____

Received by_____

Attachment 2

Five Rivers Carpenters District Council Health and Welfare Fund
HRA Account Reimbursement Form

PLEASE USE ONE CLAIM FORM PER PERSON

(See instructions on reverse side) ☐ 1st submission ☐ Adjustment ☐ Appeal

MEMBER INFORMATION – MUST BE COMPLETED (Please Print)

_____ **SS #** _____

Member's Name (Last, First, MI)

_____ _____ _____ _____ (_____) _____

Address City State Zip Code Daytime Phone Number

HEALTH CARE EXPENSES (HRA) – MUST BE COMPLETED (see instructions on reverse)

	Date of Service					
Patient's Name	**From**	**To**	**Type of Service (i.e. copays, deductible, coinsurance, member responsibility)**	**Provider Name (i.e. physician, hospital, dentist, pharmacy)**	**Do you have other coverage for this service (attach EOB)**	**Amount of Expense to be Reimbursed**
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
			Total reimbursement requested from your HRA Account **REIMBURSEMENT WILL BE SENT TO THE PARTICIPANT**			$

❖ I hereby certify that:

- The information given on this reimbursement form is complete and correct.
- I have not received reimbursement for these expenses from the reimbursement account or from any other source.
- All health care expenses listed above comply with requirements and guidelines listed on page 2 of this form.

This authorizes any, hospital, physician, or pharmacy (or any other agents) to release or receive all information with respect to myself or any of my dependents for use in connection with the administration of this plan or any other plan providing benefits or services to me, to any of my dependents, or for related health benefits services.

X _____ _____/_____/_____

Member's Signature (If submitted without signature claim(s) will be denied) Date

Mail your completed form to: **Five Rivers Carpenters District Council Health and Welfare Fund**
1831 16th Avenue SW
Cedar Rapids, IA 52404

RETURN THIS PAGE ONLY ALONG WITH THE REQUIRED PROPER DOCUMENTATION
FORMS WILL BE RETURNED IF NOT COMPLETED PROPERLY

Instructions:

1. Complete Member Information section (please print).
2. Complete Health Care Expense section as appropriate. **Service must be incurred & PAID before being reimbursed**.
3. Attached all required supporting documentation.
   Supporting Documentation: The type of documentation described under either A or B below **must** be attached to the completed form.

   A. Explanation of Benefits form (EOB): This is the form you receive each time you or a health care provider submit claims for payment of your health, dental or vision care plan. The EOB will show the amount of expenses paid or denied by the plan and the amount you must pay. For all health care expenses that are partially covered by your (or your spouse's) health, dental, or vision care plans, you **must** attach an EOB.

   B. All other Expenses: For expenses not covered at all by your (or your spouse's) health, dental, or vision care plans, reimbursement request **will not be processed** without acceptable evidence of your expenses. A cancelled check is not considered acceptable evidence. Acceptable evidence includes receipts, which contain the following information:

      - Name of person for whom the service/supply was provided
      - Date expense was incurred
      - Type of service (i.e. copay, deductible, coinsurance, dental, vision, RX, over the counter drugs)
      - Name of provider (i.e., physician, hospital, dentist, pharmacy)
      - Amount of expense(s)

4. Please provide a copy of the **paid** receipt for each requested reimbursement.
5. **Sign and Date the form (if submitted without employee signature claim(s) will be denied)**
6. Please make copies for your records, as these documents will not be returned.
7. Mail the completed form and attachment(s) to: **Five Rivers Carpenters District Council Health and Welfare Fund, 1831 16th Avenue SW, Cedar Rapids, IA 52404**
8. If you have any questions regarding your reimbursement account or claims, please call the customer service number or visit the member website address at www.5RCbenefits.com
9. Checks will not be distributed until accumulated reimbursement amounts exceed $25.

General Reimbursement Guidelines:

- Reimbursement is not a guarantee that this payment is tax-free.
- Health care expenses reimbursed through this account cannot be deducted on your federal income tax return.
- Expenses can only be submitted for reimbursement if they were for you or for eligible individuals under this plan.
- Reimbursement will only be made in accordance with the provisions of the plan. You accept responsibility for the proper treatment of benefits paid under this plan with respect to eligibility, income tax reporting and liability.

ADDITIONAL HRA FORMS CAN BE FOUND ON THE WEBSITE UNDER
FORMS & DOCUMENTS; www.5RCbenefits.com

HRA qualified medical expenses

This is a quick reference list of expenses that can be reimbursed from your health reimbursement arrangement (HRA) account. It is not intended to be comprehensive itemization, but is only intended to provide a sample list of eligible expenses the Trustees believe are reimbursable. Remember only the IRS can determine what is or is not an allowable expense from an HRA account.

For a more comprehensive list of Medical expenses that are allowed as deductions by Section 213 (d) of the Internal Revenue Code, please refer to IRS Publication 502 titled. "Medical and Dental Expenses," Catalog Number 15002Q. You can order the publication by calling (800) TAX-Form or see it online at www.irsgov/pub/irs-pdf/p502.pdf. For tax advice, please seek the services of a competent professional.

Eligible medical expenses

- Abdominal supports
- Acupuncture
- Alcoholism treatment
- Ambulance
- Anesthetist
- Arch supports
- Artificial limbs
- Birth control pills (by prescription)
- Blood tests
- Blood transfusions
- Braces
- Cardiographs
- Chiropractor
- Christian Science practitioner
- Contact lenses
- Contraceptive devices (by prescription)
- Convalescent home (for medical treatment only)
- Crutches
- Dental amounts in excess of plan maximum
- Dental benefit deductible
- Dental treatment
- Dental X-rays
- Dentures
- Dermatologist
- Diagnostic fees
- Diathermy
- Drug addiction therapy
- Elastic hosiery (prescription)
- Eyeglasses
- Guide dog
- Gum treatment
- Medical amounts in excess of plan maximum
- Medical benefit co-pay
- Medical benefit deductible
- Prescription amounts in excess of plan maximum
- Prescription benefit co-pay
- Prescription benefit deductible
- Psychoanalyst
- Psychologist
- Psychotherapy
- Radium therapy
- Registered nurse
- Special school costs for the handicapped
- Spinal fluid test
- Splints
- Sterilization
- Surgeon
- Therapy equipment
- Ultraviolet ray treatment
- Vaccines
- Vasectomy
- Vision Care amounts in excess of plan maximum
- Vision Care co-pay
- Vision Care deductible
- Vitamins (if prescribed)
- Wheelchair
- X-rays

Eligible over-the counter drugs

- Insulin

Some more specific examples of what is an allowable medical reimbursement.

Eye Surgery

You can include in medical expenses the amount you pay for eye surgery to treat defective vision, such as laser eye surgery or radial keratotomy.

Dental Treatment

You can include in medical expenses the amounts you pay for the prevention and alleviation of dental disease. Preventive treatment includes the services of a dental hygienist or dentist for such procedures as teeth cleaning, the application of sealants, and fluoride treatments to prevent tooth decay. Treatment to alleviate dental disease include services of a dentist for procedures such as X-rays, fillings, braces, extractions, dentures, and other dental ailments. Note: Teeth Whitening Are Not Includible.

Stop-Smoking Programs
You can include in medical expenses amounts you pay for a program to stop smoking. However, you cannot include in medical expenses amounts you pay for drugs that do not require a prescription, such as nicotine gum or patches, that are designed to help stop smoking.

Weight-Loss Program
You can include in medical expenses amounts you pay to lose weight if it is a treatment for a specific disease diagnosed by a physician (such as obesity, hypertension, or heart disease). This includes fees you pay for membership in a weight reduction group as well as fees for attendance at periodic meetings. You cannot include membership dues in a gym, health club, or spa as medical expenses, but you can include separate fees charged there for weight loss activities.

You cannot include the cost of diet food or beverages in medical expenses because the diet food and beverages substitute for what is normally consumed to satisfy nutritional needs. You can include the cost of special food in medical expenses only if:

1. The food does not satisfy normal nutritional needs,
2. The food alleviates or treats an illness, and
3. The need for the food is substantiated by a physician

The amount you can include in medical expenses is limited to the amount by which the cost of the special food exceeds the cost of a normal diet.

The following is a list of items of expenses the Trustees believe **are not** reimbursable.

Ineligible medical expenses		
• Advance payment for services to be rendered next year • Athletic club membership • Automobile insurance premium allocable to medical coverage • Boarding school fees • Bottled water • Commuting expenses of a disabled person • Cosmetic surgery and procedures • Cosmetics, hygiene products and similar items • Funeral, cremation or burial expenses	• Health programs offered by resort hotels, health clubs and gyms • Illegal operations and treatments • Illegally procured drugs • Maternity clothes • Penalties for failure to precertify according to health plan rules • Premiums for life insurance, income protection, disability, loss of limbs, sight or similar benefits • Scientology counseling • Social activities	• Special foods and beverages • Specially designed car for the handicapped • Swimming pool • Travel for general health improvement • Tuition and travel expenses to send a problem child to a particular school
Ineligible over-the-counter drugs		
• Acne treatments • Allergy medications • Antacids • Antibiotic ointments • Anti-diarrhea medicine • Calamine lotion • Cold medicine • Cosmetics (including face cream and moisturizer) • Cough drops and throat lozenges • Dietary supplements	• Fiber supplements • First and creams • Herbs • Lip balm (including Chapstick® or Carmex®) • Medicated shampoos and soaps • Motion sickness pills • Nasal sprays • Nicotine medications • Pain relievers • Pedialyte®	• Sleep aids • Sinus medications and nasal sprays • Suppositories and creams for hemorrhoids • Toiletries (including toothpaste) • Vitamins (daily) • Wart removal medication • Weight-loss drugs for general wellbeing

Attachment 3

Five Rivers Carpenters District Council Health & Welfare Fund
HRA Account Reimbursement Form

REQUEST FOR DIRECT PAYMENT TO PROVIDER

This Claim Form **ONLY** applies to the following types of claims:

Orthodontic care
Lasik eye surgery
Hearing aids
Dental claims above the Maximum Benefit Payable Amount in the Schedule of Benefits

PLEASE USE ONE CLAIM FORM PER PERSON

(See instructions on reverse side) ☐ 1st submission ☐ Adjustment ☐ Appeal

MEMBER INFORMATION – MUST BE COMPLETED (Please Print)

_____ **SS #** _____
Member's Name (Last, First, MI)

_____ _____ _____ _____ (_____) _____
Address City State Zip Code Daytime Phone Number

HEALTH CARE EXPENSES (HRA) – MUST BE COMPLETED (see instructions on reverse)

	Date of Service					
Patient's Name			**Type of Service (i.e. orthodontic, Lasik eye surgery, hearing aids, dental claim)**	**Provider Name (i.e. physician, hospital, dentist, pharmacy)**	**Do you have other coverage for this service (attach EOB)**	**Amount of Expense to be Reimbursed**
1.						
2.						
3.						
4.						
5.						
			Total reimbursement requested from your HRA Account **REIMBURSEMENT WILL BE SENT DIRECTLY TO THE PROVIDER**			$

- ❖ I hereby certify that:
  - The information given on this reimbursement form is complete and correct.
  - I have not received reimbursement for these expenses from the reimbursement account or from any other source.
  - All health care expenses listed above comply with requirements and guidelines listed on page 2 of this form.

This authorizes any, hospital, physician, or pharmacy (or any other agents) to release or receive all information with respect to myself or any of my dependents for use in connection with the administration of this plan or any other plan providing benefits or services to me, to any of my dependents, or for related health benefits services.

X _____ _____/_____/_____
Member's Signature (If submitted without signature claim(s) will be denied) Date

Mail your completed form to: **Five Rivers Carpenters H&W Fund**
1831 16th Avenue SW
Cedar Rapids, IA 52404

RETURN THIS PAGE ONLY ALONG WITH THE REQUIRED PROPER DOCUMENTATION
FORMS WILL BE RETURNED IF NOT COMPLETED PROPERLY

Instructions:

1. Complete Member Information section (please print).
2. Complete Health Care Expense section as appropriate. **Service must be incurred before being reimbursed (except for Orthodontia, below)**. Only the following services may be paid directly to the provider by use of this form: Orthodontic care, Lasik eye surgery, hearing aids, and dental claims above the Maximum Benefit Payable Amount in the Schedule of Benefits.
3. Attach all required supporting documentation.
   Supporting Documentation: The type of documentation described under either A or B below **must** be attached to the completed form.

   A. Explanation of Benefits form (EOB): This is the form you receive each time you or a health care provider submit claims for payment of your health, dental or vision care plan. The EOB will show the amount of expenses paid or denied by the plan and the amount you must pay. For all health care expenses that are partially covered by your (or your spouse's) health, dental, or vision care plans, you **must** attach an EOB.

   B. All other Expenses: For expenses not covered at all by your (or your spouse's) health, dental, or vision care plans, reimbursement request **will not be processed** without acceptable evidence of your expenses. Acceptable evidence includes the following information:

      - Name of person for whom the service/supply was provided
      - Date expense was incurred
      - Type of service (i.e. orthodontic care, Lasik eye surgery, hearing aids, or dental claim)
      - Name of provider (i.e., physician, hospital, dentist, orthodontist)
      - Amount of expense(s)

4. Please provide a copy of the invoice from the Provider for each requested reimbursement.
5. **Sign and Date the form (if submitted without employee signature claim(s) will be denied)**
6. Please make copies for your records, as these documents will not be returned.
7. Mail the completed form and attachment(s) to: **Five River Carpenters H&W Fund, 1831 16th Avenue SW, Cedar Rapids, IA 52404**
8. If you have any questions regarding your reimbursement account or claims, please call the customer service number or visit the member website address at www.5RCbenefits.com.
9. Your provider will be paid only the amount you have in accumulated reimbursement amounts at the time your claim form is received. You will be responsible for paying to the provider any amount above the accumulated reimbursement amount.

Orthodontia
Orthodontia services may be paid before the services are provided and are deemed to be incurred when advance payment is made. Advance payment may be made in a lump sum or payments over time. You must submit documentation from the orthodontist showing the name of the person receiving the treatment, the beginning date of the treatment, the contracted amount, and the amount to be paid (Financial Agreement Contract, itemized statement and claim form are required). The Financial Agreement Contract with the Provider must be signed by the Provider and the Member.

General Reimbursement Guidelines:

- Reimbursement is not a guarantee that this payment is tax-free.
- Health care expenses reimbursed through this account cannot be deducted on your federal income tax return.
- Expenses can only be submitted for reimbursement if they were for you or for eligible individuals under this plan.
- Reimbursement will only be made in accordance with the provisions of the plan. You accept responsibility for the proper treatment of benefits paid under this plan with respect to eligibility, income tax reporting and liability.

ADDITIONAL HRA FORMS CAN BE FOUND ON THE WEBSITE UNDER FORMS & DOCUMENTS; www.5RCbenefits.com

HRA qualified medical expenses

This is a quick reference list of expenses that can be reimbursed from your health reimbursement arrangement (HRA) account. It is not intended to be comprehensive itemization, but is only intended to provide a sample list of eligible expenses the Trustees believe are reimbursable. Remember only the IRS can determine what is or is not an allowable expense from an HRA account.

For a more comprehensive list of Medical expenses that are allowed as deductions by Section 213(d) of the Internal Revenue Code, please refer to IRS Publication 502 titled. "Medical and Dental Expenses," Catalog Number 15002Q. You can order the publication by calling (800) TAX-Form or see it online at www.irsgov/pub/irs-pdf/p502.pdf. For tax advice, please seek the services of a competent professional.

	Eligible medical expenses		
	• Abdominal supports • Acupuncture • Alcoholism treatment • Ambulance • Anesthetist • Arch supports • Artificial limbs • Birth control pills (by prescription) • Blood tests • Blood transfusions • Braces • Cardiographs • Chiropractor • Christian Science practitioner • Contact lenses • Contraceptive devices (by prescription) • Convalescent home (for medical treatment only) • Crutches • Dental amounts in excess of plan maximum	• Dental benefit deductible • Dental treatment • Dental X-rays • Dentures • Dermatologist • Diagnostic fees • Diathermy • Drug addiction therapy • Elastic hosiery (prescription) • Eyeglasses • Guide dog • Gum treatment • Medical amounts in excess of plan maximum • Medical benefit co-pay • Medical benefit deductible • Prescription amounts in excess of plan maximum • Prescription benefit co-pay • Prescription benefit deductible • Psychoanalyst	• Psychologist • Psychotherapy • Radium therapy • Registered nurse • Special school costs for the handicapped • Spinal fluid test • Splints • Sterilization • Surgeon • Therapy equipment • Ultraviolet ray treatment • Vaccines • Vasectomy • Vision Care amounts in excess of plan maximum • Vision Care co-pay • Vision Care deductible • Vitamins (if prescribed) • Wheelchair • X-rays
	Eligible over-the counter drugs		
	• Insulin		

Some more specific examples of what is an allowable medical reimbursement.

Eye Surgery
You can include in medical expenses the amount you pay for eye surgery to treat defective vision, such as laser eye surgery or radial keratotomy.

Dental Treatment
You can include in medical expenses the amounts you pay for the prevention and alleviation of dental disease. Preventive treatment includes the services of a dental hygienist or dentist for such procedures as teeth cleaning, the application of sealants, and fluoride treatments to prevent tooth decay. Treatment to alleviate dental disease include services of a dentist for procedures such as X-rays, fillings, braces, extractions, dentures, and other dental ailments. Note: Teeth Whitening Are Not Includible.

Stop-Smoking Programs
You can include in medical expenses amounts you pay for a program to stop smoking. However, you cannot include in medical expenses amounts you pay for drugs that do not require a prescription, such as nicotine gum or patches, that are designed to help stop smoking.

Weight-Loss Program
You can include in medical expenses amounts you pay to lose weight if it is a treatment for a specific disease diagnosed by a physician (such as obesity, hypertension, or heart disease). This includes fees you pay for membership in a weight reduction group as well as fees for attendance at periodic meetings. You cannot include membership dues in a gym, health club, or spa as medical expenses, but you can include separate fees charged there for weight loss activities.

You cannot include the cost of diet food or beverages in medical expenses because the diet food and beverages substitute for what is normally consumed to satisfy nutritional needs. You can include the cost of special food in medical expenses only if:

4. The food does not satisfy normal nutritional needs,
5. The food alleviates or treats an illness, and
6. The need for the food is substantiated by a physician

The amount you can include in medical expenses is limited to the amount by which the cost of the special food exceeds the cost of a normal diet.

The following is a list of items of expenses the Trustees believe **are not** reimbursable.

Ineligible medical expenses		
• Advance payment for services to be rendered next year • Athletic club membership • Automobile insurance premium allocable to medical coverage • Boarding school fees • Bottled water • Commuting expenses of a disabled person • Cosmetic surgery and procedures • Cosmetics, hygiene products and similar items • Funeral, cremation or burial expenses	• Health programs offered by resort hotels, health clubs and gyms • Illegal operations and treatments • Illegally procured drugs • Maternity clothes • Penalties for failure to precertify according to health plan rules • Premiums for life insurance, income protection, disability, loss of limbs, sight or similar benefits • Scientology counseling • Social activities	• Special foods and beverages • Specially designed car for the handicapped • Swimming pool • Travel for general health improvement • Tuition and travel expenses to send a problem child to a particular school
Ineligible over-the-counter drugs		
• Acne treatments • Allergy medications • Antacids • Antibiotic ointments • Anti-diarrhea medicine • Calamine lotion • Cold medicine • Cosmetics (including face cream and moisturizer) • Cough drops and throat lozenges • Dietary supplements	• Fiber supplements • First and creams • Herbs • Lip balm (including Chapstick® or Carmex®) • Medicated shampoos and soaps • Motion sickness pills • Nasal sprays • Nicotine medications • Pain relievers • Pedialyte®	• Sleep aids • Sinus medications and nasal sprays • Suppositories and creams for hemorrhoids • Toiletries (including toothpaste) • Vitamins (daily) • Wart removal medication • Weight-loss drugs for general wellbeing

Attachment 4

Five Rivers Carpenters District Council Health and Welfare Fund
Election for Use of HRA Account
for Participant Promoted to a Category Not Covered by the CBA

You must make an election using this Form within 30 days of your promotion to a category not covered by the Collective Bargaining Agreement. You will not receive reimbursement under the HRA until this Election has been returned:

Mail your completed form to: **Five Rivers Carpenters H&W Fund**
1831 16th Avenue SW
Cedar Rapids, IA 52404

I, _____, was promoted to a category not covered by the Collective Bargaining Agreement with a Contributing Employer on _____ ____, 20___ . I choose to make the following election regarding my HRA Account.

Please initial an option; you can only elect <u>one</u> option.

_____ Option 1. I am working for a Contributing Employer in a non-bargaining capacity, and the Contributing Employer contributes a monthly premium to this Plan on my behalf for coverage in the Fund pursuant to a Participation Agreement with the Fund.

_____ Option 2. I am working for a Contributing Employer, and the Contributing Employer covers me and my Dependents under a group health plan. I agree to notify the Third Party Administrator immediately if I, or any of my Dependents, no longer have coverage under the group health plan.

_____ Option 3. I am working for a Contributing Employer, and I have coverage under a group health plan through an employer of my spouse. This coverage covers me and my Dependents. I agree to notify the Third Party Administrator immediately if I, or any of my Dependents, no longer have coverage under this group health plan.

_____ Option 4: I am working for a contributing Employer and I request my DB and HRA accounts be frozen for the quarter commencing after I was promoted until I return to the Bargaining Unit and make myself available for full time employment. At that time, I should have, upon my request in writing to the Third-Party Administrator within 30 days of my return to the Bargaining Unit, my HRA account unfrozen.

_____ Option 5: I desire to permanently opt out of or waive future reimbursements from the HRA.

Signature: _____ Dated: _____

Received by: _____

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

Five Rivers Carpenters District Council Health & Welfare Fund

Group Effective Date: 1/1/2023
Plan Year: January 1
Product ID: PL000376

Wellmark Blue Cross and Blue Shield of Iowa is an independent licensee of the Blue Cross and Blue Shield Association.

AllianceSelect℠
Five Rivers Carpenters District Council PPO

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.

Group Effective Date: 1/1/2023
Plan Year: January 1
Print Date: 4/18/2023
Product ID: PL000376
Version: 01/23

Form Number: Wellmark IA Grp

Contents

About This Summary Plan Description

Important Information

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

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

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

Charts

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

Complete Information

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

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

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

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.

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

This group benefits plan is maintained pursuant to a collective bargaining agreement. A copy of the agreement may be obtained by participants and beneficiaries upon written request to the local union hall and is available for examination by participants and beneficiaries, as required by 29 CFR §§2520.104b-1 *et seq*.

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.

Provider Network

Under the medical benefits of this plan, your network of providers consists of PPO and Participating providers. All other providers are Out-of-Network Providers. Which provider type you choose will affect what you pay.

PPO Providers. These providers participate with the Wellmark Blue PPO℠ network or with a Blue Cross and/or Blue Shield PPO network in another state or service area. You typically pay the least for services received from these providers. Throughout this summary plan description we refer to these providers as PPO Providers.

Participating Providers. These providers participate with a Blue Cross and/or Blue Shield Plan in another state or service area, but not with a PPO network. You typically pay more for services from these providers than for services from PPO Providers. Throughout this summary plan description we refer to these providers as Participating Providers.

Out-of-Network Providers. Out-of-Network Providers do not participate with Wellmark or any other Blue Cross and/or Blue Shield Plan. You typically pay the most for services from these providers.

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.

You Pay
Deductible **$300** per person for covered services received from PPO Providers. **$600** (maximum) per family* for covered services received from PPO Providers. **$900** per person for covered services received from Participating and Out-of-Network providers. **$1,800** (maximum) per family* for covered services received from Participating and Out-of-Network providers.
Coinsurance **20%** for covered services received from PPO Providers. **30%** for covered services received from Participating and Out-of-Network providers.
Out-of-Pocket Maximum **$3,000** per person for covered services received from PPO and Participating providers. **$6,000** (maximum) per family* for covered services received from PPO and Participating providers. **$9,000** per person for covered services received from Out-of-Network Providers. **$18,000** (maximum) per family* for covered services received from Out-of-Network Providers.

*Family amounts are reached from amounts accumulated on behalf of any combination of covered family members. A member will not be required to satisfy more than the single deductible before we make benefit payments for that member.

Payment Details

Deductible

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

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

A member will not be required to satisfy more than the single deductible before we make benefit payments for that member.

Deductible amounts you pay for PPO or Participating and Out-of-Network provider services apply toward meeting both the PPO and the Participating/Out-of-Network deductibles. The maximum deductible amount you pay is the Participating/Out-of-Network deductible.

Once you meet the deductible, then coinsurance applies.

When the No Surprises Act applies, you may not be required to satisfy your entire deductible before we make benefit payments, amounts you pay for items and services will accumulate toward your PPO deductible, and you may not be billed for more than the amount you would pay if the services had been provided by a Participating Provider. The No Surprises Act typically applies to emergency services at an Out-of-Network facility, non-emergency items and services from Out-of-Network Providers at certain participating facilities, and air ambulance services.

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

Coinsurance

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

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

Out-of-Pocket Maximum

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

- Coinsurance.

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

A member will not be required to satisfy more than the single out-of-pocket maximum.

There is an out-of-pocket maximum for services you receive from PPO Providers and Participating Providers. There is also an out-of-pocket maximum for services you receive from Out-of-Network Providers. These out-of-pocket maximums accumulate to one another.

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

- Amounts representing any general exclusions and conditions. See *General Conditions of Coverage, Exclusions, and Limitations*, page 29.
- Deductible.
- Difference in cost between the provider's amount charged and our maximum allowable fee when you receive services from an Out-of-Network Provider.

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

When the No Surprises Act applies, amounts you pay for items and services will accumulate toward your PPO out-of-pocket maximum and you may not be billed for more than the amount you would pay if the services had been provided by a Participating Provider. The No Surprises Act typically applies to emergency services at an Out-of-Network facility, non-emergency items and services from Out-of-Network Providers at certain participating facilities, and air ambulance services.

Benefits Maximums

Benefits maximums are the maximum benefit amounts that each member is eligible to receive.

Benefits maximums that apply per benefit year 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.

No Surprises Act

When the No Surprises Act applies, the amount you pay will be determined in accordance with the Act and you may not be billed for more than the amount you would pay if the services had been provided by a Participating Provider. The No Surprises Act typically applies to emergency services at an Out-of-Network facility, non-emergency items and services from Out-of-Network Providers at certain participating facilities, and air ambulance services.

Waived Payment Obligations

To understand your complete payment obligations you must become familiar with this entire summary plan description. Most information on coverage and benefits maximums will be found in the *At a Glance – Covered and Not Covered* and *Details – Covered and Not Covered* sections.

Some payment obligations are waived for the following covered services.

Covered Service	Payment Obligation Waived
Breast pumps (manual or non-hospital grade electric) purchased from a covered home/durable medical equipment provider.	Deductible Coinsurance
Breastfeeding support, supplies, and one-on-one lactation consultant services, including counseling and education, during pregnancy and/or the duration of breastfeeding.	Deductible Coinsurance
Contraceptive medical devices, such as intrauterine devices and diaphragms.	Deductible Coinsurance
Implanted and injected contraceptives.	Deductible Coinsurance
Medical evaluations and counseling for nicotine dependence per U.S. Preventive Services Task Force (USPSTF) guidelines.	Deductible Coinsurance
Postpartum home visit (one).	Deductible Coinsurance

Covered Service	Payment Obligation Waived
Preventive care, items, and services* as follows: ■ Items or services with an "A" or "B" rating in the current recommendations of the United States Preventive Services Task Force (USPSTF); ■ Immunizations as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (ACIP); ■ Preventive care and screenings for infants, children, and adolescents provided for in guidelines supported by the Health Resources and Services Administration (HRSA); and ■ Preventive care and screenings for women provided for in guidelines supported by the HRSA.	Deductible Coinsurance
Preventive digital breast tomosynthesis (3D mammogram).	Deductible Coinsurance
Telehealth services.‡	Deductible Coinsurance
Voluntary sterilization for female members.	Deductible Coinsurance

*A complete list of recommendations and guidelines related to preventive services can be found at *www.healthcare.gov*. Recommended preventive services are subject to change and are subject to medical management. USPSTF "A" and "B" recommendations will be implemented no later than the first plan year that begins on or after the date that is one year after the USPSTF recommendations are issued. A USPSTF recommendation is considered to be issued on the last day of the month on which it publishes or otherwise releases the recommendation. Waived Payment Obligations will be effective following implementation of the USPSTF recommendation.

‡Members can access telehealth services from Doctor on Demand through the Doctor on Demand mobile application or through *myWellmark.com*.

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 11. 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 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
Acupuncture Treatment		⦸	11	
Allergy Testing and Treatment	●		11	
Ambulance Services	●		11	
Anesthesia	●		12	
Autism Treatment	●		12	
Biofeedback		⦸	12	
Blood and Blood Administration	●		12	
Chemical Dependency Treatment	●		12	
Chemotherapy and Radiation Therapy	●		13	
Clinical Trials – Routine Care Associated with Clinical Trials	●		13	
Contraceptives	●		13	
Conversion Therapy		⦸	13	
Cosmetic Services		⦸	13	
Counseling and Education Services		⦸	14	

Category	Covered	Not Covered	See Page	Benefits Maximums
Dental Treatment for Accidental Injury	●		14	
Dialysis	●		15	
Education Services for Diabetes and Nutrition	●		15	
Emergency Services	●		15	
Fertility Services	●		15	
Genetic Testing	●		16	
Hearing Services	●		16	
Home Health Services	●		16	The daily benefit for extended home skilled nursing services will not exceed Wellmark's daily maximum allowable fee for skilled nursing facility services. The daily benefit for short-term home skilled nursing services will not exceed Wellmark's daily maximum allowable fee for skilled nursing facility services.
Home/Durable Medical Equipment	●		17	
Hospice Services	●		18	
Hospitals and Facilities	●		18	
Illness or Injury Services	●		19	
Infertility Treatment		⦸	19	
Inhalation Therapy	●		19	
Maternity Services	●		19	
Medical and Surgical Supplies and Personal Convenience Items	●		20	
Mental Health Services	●		20	
Motor Vehicles		⦸	21	
Musculoskeletal Treatment	●		22	$500 per benefit year for chiropractic services received from Participating and Out-of-Network providers.
Nonmedical or Administrative Services		⦸	22	
Nutritional and Dietary Supplements	●		22	
Obesity Treatment		⦸	22	
Occupational Therapy	●		22	
Orthotics (Foot)	●		23	$300 per benefit year.

Category	Covered	Not Covered	See Page	Benefits Maximums
Physical Therapy	●		23	
Physicians and Practitioners			23	
Advanced Registered Nurse Practitioners	●		23	
Audiologists	●		23	
Chiropractors	●		23	$500 per benefit year for chiropractic services received from Participating and Out-of-Network providers.
Doctors of Osteopathy	●		23	
Licensed Independent Social Workers	●		23	
Licensed Marriage and Family Therapists		⦸	24	
Licensed Mental Health Counselors	●		23	
Medical Doctors	●		23	
Occupational Therapists	●		23	
Optometrists	●		23	
Oral Surgeons	●		23	
Physical Therapists	●		23	
Physician Assistants	●		23	
Podiatrists	●		23	
Psychologists	●		23	
Speech Pathologists	●		24	
Prescription Drugs	●		24	
Preventive Care	●		24	Well-child care until the child reaches age 26. One routine physical examination per benefit year. One routine mammogram per benefit year. One routine gynecological examination per benefit year. One routine Pap smear per benefit year.
Prosthetic Devices	●		25	
Reconstructive Surgery	●		25	
Self-Help Programs		⦸	26	
Sleep Apnea Treatment	●		26	
Social Adjustment		⦸	26	
Speech Therapy	●		26	
Surgery	●		26	
Telehealth Services	●		26	
Temporomandibular Joint Disorder (TMD)		⦸	26	
Transplants	●		26	
Travel or Lodging Costs		⦸	27	

Category	Covered	Not Covered	See Page	Benefits Maximums
Vision Services (related to an illness or injury)	●		27	
Wigs or Hairpieces		⦸	27	
X-ray and Laboratory Services	●		27	

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

Acupuncture Treatment

Not Covered: Acupuncture and acupressure treatment.

Allergy Testing and Treatment

Covered.

Ambulance Services

Covered:

- Emergency air and ground ambulance transportation to a hospital.

  All of the following are required to qualify for benefits:

  - If you are inpatient, the services required to treat your illness or injury are not available where you are currently receiving care.
  - You are transported to the nearest hospital with adequate facilities to treat your medical condition.
  - During transport, your medical condition requires the services that are provided only by an air or ground ambulance.
  - Your medical condition requires immediate ambulance transport.
  - In addition to the preceding requirements, for emergency air ambulance services to be covered, the following must be met:
    - Great distances, inaccessibility of the pickup location by a land vehicle, or other obstacles are involved in getting you to the nearest hospital with appropriate facilities for treatment by ground transport.

  When the No Surprises Act applies to air ambulance services, you cannot be billed for the difference between the amount charged and the total amount paid by us.

  In an emergency situation, if you cannot reasonably utilize a PPO ambulance service, covered services will be reimbursed as though they were received from a non-PPO ambulance service. However, if ground ambulance services are provided by an Out-of-Network Provider, and because we do not have contracts with Out-of-Network Providers and they may not accept our payment arrangements, you may be responsible for any difference between the amount charged and our amount paid for a covered service. When receiving ground ambulance services, select a provider who participates in your network to avoid being responsible for any difference between the billed charge and our settlement amount.

- Non-emergency air or ground ambulance transportation to a hospital or nursing facility.

  All of the following are required to qualify for benefits:

  - The services required to treat your illness or injury are not available where you are currently receiving care.
  - You are transported to the nearest hospital or nursing facility with adequate facilities to treat your medical condition.
  - During transport your medical condition requires the services that are provided only by an air or ground ambulance.
  - In addition to the preceding requirements, for non-emergency air

ambulance services to be covered, all of the following must be met:

- You must already be receiving care at a hospital.
- Great distances, inaccessibility of the pickup location by a land vehicle, or other obstacles are involved in getting you to the nearest hospital or nursing facility with appropriate facilities for treatment by ground transport.

Not Covered:

- Air or ground ambulance transport from a facility capable of treating your condition.
- Air or ground ambulance transport to or from any location when you are physically and mentally capable of being a passenger in a private vehicle.
- Round-trip transports from your residence to a medical provider for an appointment or treatment and back to your residence.
- Air or ground transport when performed primarily for your convenience or the convenience of your family, physician, or other health care provider, such as a transfer to a hospital or facility that is closer to your home or family.
- Non-ambulance transport to any location for any reason. This includes private vehicle transport, commercial air transport, police transport, taxi, public transportation such as train or bus, ride-share vehicles such as Uber or Lyft, and vehicles such as vans or taxis that are equipped to transport stretchers or wheelchairs but are not professionally operated or staffed.

Anesthesia

Covered: Anesthesia and the administration of anesthesia.

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

Autism Spectrum Disorder Treatment

Covered: Diagnosis and treatment of autism spectrum disorder and Applied Behavior Analysis services when Applied Behavior Analysis services are performed or supervised by a licensed physician or psychologist or a master's or doctoral degree holder certified by the National Behavior Analyst Certification Board with a designation of board certified behavior analyst. Applied Behavior Analysis services are also covered for treatment of conditions other than autism spectrum disorder.

Biofeedback

Not Covered.

Blood and Blood Administration

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

Chemical Dependency Treatment

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

Licensed Substance Abuse Treatment Program. Benefits are available for chemical dependency treatment in the following settings:

- Treatment provided in an office visit, or outpatient setting;
- Treatment provided in an intensive outpatient setting;
- Treatment provided in an outpatient partial hospitalization setting;
- Drug or alcohol rehabilitation therapy or counseling provided while participating in a clinically managed low intensity residential treatment setting, also known as supervised living;

- Treatment, including room and board, provided in a clinically managed medium or high intensity residential treatment setting;
- Treatment provided in a medically monitored intensive inpatient or detoxification setting; and
- For inpatient, medically managed acute care for patients whose condition requires the resources of an acute care general hospital or a medically managed inpatient treatment program.

Not Covered:

- Room and board provided while participating in a clinically managed low intensity residential treatment setting, also known as supervised living.
- Recreational activities or therapy, social activities, meals, excursions or other activities not considered clinical treatment, while participating in substance abuse treatment programs.

See Also:

Hospitals and Facilities later in this section.

Notification Requirements and Care Coordination, page 41.

Chemotherapy and Radiation Therapy

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

Clinical Trials – Routine Care Associated with Clinical Trials

Covered: Medically necessary routine patient costs for items and services otherwise covered under this plan furnished in connection with participation in an approved clinical trial related to the treatment of cancer or other life-threatening diseases or conditions, when a covered member is referred by a PPO or Participating provider based on the conclusion that the member is eligible to participate in an approved clinical trial according to the trial protocol or the member provides medical and scientific information establishing that the member's participation in the clinical trial would be appropriate according to the trial protocol.

Not Covered:

- Investigational or experimental items, devices, or services which are themselves the subject of the clinical trial;
- Clinical trials, items, and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;
- Services that are clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Contraceptives

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

- Contraceptive medical devices, such as intrauterine devices and diaphragms.
- Implanted contraceptives.
- Injected contraceptives.

Not Covered:

- Contraceptive drugs and contraceptive drug delivery devices, such as insertable rings and patches.

Conversion Therapy

Not Covered: Conversion therapy services.

Cosmetic Services

Not Covered: Cosmetic services, supplies, or drugs if provided primarily to improve physical appearance. However, a service, supply, or drug that results in an incidental improvement in appearance may be covered if it is provided primarily to restore function lost or impaired as the result of an illness, accidental injury, or a birth defect. You are also not covered for treatment for any complications resulting from a noncovered cosmetic procedure.

See Also:

Reconstructive Surgery later in this section.

Counseling and Education Services

Not Covered:

- Services and supplies associated with bereavement counseling or services.
- Services and supplies associated with family or marriage counseling or training services.
- Community-based services or services of volunteers or clergy.
- Education or educational therapy other than covered lactation consultant services, education for self-management of diabetes, or nutrition education.
- Learning and educational services and treatments including, but not limited to, non-drug therapy for high blood pressure control, exercise modalities for weight reduction, nutritional instruction for the control of gastrointestinal conditions, or reading programs for dyslexia, for any medical, mental health, or substance abuse condition.

See Also:

Genetic Testing later in this section.

Education Services for Diabetes and Nutrition later in this section.

Mental Health Services later in this section.

Preventive Care later in this section.

Dental Services

Covered:

- Dental treatment for accidental injuries when:
  - Treatment is completed within six months of the injury.
- Anesthesia (general) and hospital or ambulatory surgical facility services related to covered dental services if:
  - You are under age 14 and, based on a determination by a licensed dentist and your treating physician, you have a dental or developmental condition for which patient management in the dental office has been ineffective and requires dental treatment in a hospital or ambulatory surgical facility; or
  - Based on a determination by a licensed dentist and your treating physician, you have one or more medical conditions that would create significant or undue medical risk in the course of delivery of any necessary dental treatment or surgery if not rendered in a hospital or ambulatory surgical facility.
- Impacted teeth removal (surgical) as an outpatient or office. Inpatient removal is covered only when you have a medical condition (such as hemophilia) that requires hospitalization.
- Facial bone fracture reduction.
- Incisions of accessory sinus, mouth, salivary glands, or ducts.
- Jaw dislocation manipulation.
- Orthodontic services associated with management of cleft palate.
- Treatment of abnormal changes in the mouth due to injury or disease of the mouth, or dental care (oral examination, x-rays, extractions, and nonsurgical elimination of oral infection) required for the direct treatment of a medical condition, limited to:
  - Dental services related to medical transplant procedures;
  - Initiation of immunosuppressives (medication used to reduce inflammation and suppress the immune system); or
  - Treatment of neoplasms of the mouth and contiguous tissue.

Not Covered:

- General dentistry including, but not limited to, diagnostic and preventive services, restorative services, endodontic services, periodontal services, indirect fabrications, dentures and bridges, and orthodontic services unrelated to

accidental injuries or management of cleft palate.
- Injuries associated with or resulting from the act of chewing.
- Maxillary or mandibular tooth implants (osseointegration) unrelated to accidental injuries or abnormal changes in the mouth due to injury or disease.

Dialysis

Covered: Removal of toxic substances from the blood when the kidneys are unable to do so when provided as an inpatient in a hospital setting or as an outpatient in a Medicare-approved dialysis center.

Education Services for Diabetes and Nutrition

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

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

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

You are also covered for nutrition education to improve your understanding of your metabolic nutritional condition and provide you with information to manage your nutritional requirements. Nutrition education is appropriate for the following conditions:

- Cancer.
- Cystic fibrosis.
- Diabetes.
- Eating disorders.
- Glucose intolerance.
- High blood pressure.
- High cholesterol.
- Lactose intolerance.
- Malabsorption, including gluten intolerance.
- Underweight.

Emergency Services

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

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

In an emergency situation, if you cannot reasonably reach a PPO Provider, covered services will be reimbursed as though they were received from a non-PPO Provider. When the No Surprises Act applies to emergency services, you cannot be billed for the difference between the amount charged and the total amount paid by us. If you receive medically necessary emergency services to treat an emergency medical condition, those services will be covered as required under the No Surprises Act notwithstanding any other plan exclusion.

See Also:

Out-of-Network Providers, page 49.

Fertility Services

Covered:

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

Not Covered:

- Services and supplies associated with an abortion that is elective (except abortions performed when the life of the mother is at risk if the pregnancy goes to

full term and complications resulting from a noncovered abortion).

- Abortion for a dependent child and complications from a noncovered abortion for a dependent.
- Charges for contraceptives, including implantable contraceptives, injectable contraceptives (e.g., Depo-Provera), NuvaRing, oral contraceptives, the contraceptive patch, diaphragms, foam and devices for contraceptive purposes.

Genetic Testing

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

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

Hearing Services

Covered:

- Routine hearing examinations for members up to age 21.

Not Covered:

- Hearing aids.
- Routine hearing examinations for members age 21 and older.

Home Health Services

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

- You require a medically necessary skilled service such as skilled nursing, physical therapy, or speech therapy.
- Services are received from an agency accredited by the Joint Commission for Accreditation of Health Care Organizations (JCAHO) and/or a Medicare-certified agency.
- Services are prescribed by a physician and approved by Wellmark for the treatment of illness or injury.
- Services are not more costly than alternative services that would be effective for diagnosis and treatment of your condition.

The following are covered services and supplies:

Extended Home Skilled Nursing. Home skilled nursing care, other than short-term home skilled nursing, provided in the home by a registered (R.N.) or licensed practical nurse (L.P.N.) who is associated with an agency accredited by the Joint Commission for Accreditation of Health Care Organizations (JCAHO) or a Medicare-certified agency that is ordered by a physician and consists of four or more hours per day of continuous nursing care that requires the technical proficiency and knowledge of an R.N. or L.P.N. The daily benefit for extended home skilled nursing services will not exceed Wellmark's daily maximum allowable fee for care in a skilled nursing facility. Benefits do not include custodial care or services provided for the convenience of the family caregiver.

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

Short-Term Home Skilled Nursing. Treatment must be given by a registered nurse (R.N.) or licensed practical nurse (L.P.N.) from an agency accredited by the Joint Commission for Accreditation of Health Care Organizations (JCAHO) or a Medicare-certified agency. Short-term home skilled nursing means home skilled nursing care that:

— is provided for a definite limited period of time as a safe transition

from other levels of care when medically necessary;
- provides teaching to caregivers for ongoing care; or
- provides short-term treatments that can be safely administered in the home setting.

The daily benefit for short-term home skilled nursing services will not exceed Wellmark's daily maximum allowable fee for care in a skilled nursing facility. Benefits do not include maintenance or custodial care or services provided for the convenience of the family caregiver.

Inhalation Therapy.

Medical Equipment.

Medical Social Services.

Medical Supplies.

Occupational Therapy—but only for services to treat the upper extremities, which means the arms from the shoulders to the fingers. You are not covered for occupational therapy supplies.

Oxygen and Equipment for its administration.

Parenteral and Enteral Nutrition, except enteral formula administered orally.

Physical Therapy.

Prescription Drugs and Medicines administered in the vein or muscle.

Prosthetic Devices and Braces.

Speech Therapy.

Not Covered:

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

Home/Durable Medical Equipment

Covered: Equipment that meets all of the following requirements:

- The equipment is ordered by a provider within the scope of his or her license and there is a written prescription.
- Durable enough to withstand repeated use.
- Primarily and customarily manufactured to serve a medical purpose.
- Used to serve a medical purpose.
- Standard or basic home/durable medical equipment that will adequately meet the medical needs and that does not have certain deluxe/luxury or convenience upgrade or add-on features.

In addition, we determine whether to pay the rental amount or the purchase price amount for an item, and we determine the length of any rental term. Wellmark requires rental of certain medically appropriate home/durable medical equipment including, but not limited to, continuous positive airway pressure (CPAP) devices. When rental is required, you will be required to rent from a licensed DME provider for a period of ten months, and after the expiration of the ten-month period, Wellmark considers the item purchased. Benefits will never exceed the lesser of the amount charged or the maximum allowable fee.

See Also:

Medical and Surgical Supplies and Personal Convenience Items later in this section.

Orthotics (Foot) later in this section.

Prosthetic Devices later in this section.

Hospice Services

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

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

Hospitals and Facilities

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

Ambulatory Surgical Facility. This type of facility provides surgical services on an outpatient basis for patients who do not need to occupy an inpatient hospital bed and must be licensed as an ambulatory surgical facility under applicable law.

Chemical Dependency Treatment Facility. This type of facility must be licensed as a chemical dependency treatment facility under applicable law.

Community Mental Health Center. This type of facility provides treatment of mental health conditions and must be licensed as a community mental health center under applicable law.

Hospital. This type of facility provides for the diagnosis, treatment, or care of injured or sick persons on an inpatient and outpatient basis. The facility must be licensed as a hospital under applicable law.

Nursing Facility. This type of facility provides continuous skilled nursing services as ordered and certified by your attending physician on an inpatient basis for short-term care. Benefits do not include maintenance or custodial care or services provided for the convenience of the family caregiver. The facility must be licensed as a nursing facility under applicable law.

Psychiatric Medical Institution for Children (PMIC). This type of facility provides inpatient psychiatric services to children and is licensed as a PMIC under Iowa Code Chapter 135H.

Urgent Care Center. This type of facility provides medical care without an appointment during all hours of operation to walk-in patients of all ages who are ill or injured and require immediate care but may not require the services of a hospital emergency room.

Not Covered:

- Long Term Acute Care Facility.
- Room and board provided while a patient at an intermediate care facility or similar level of care.

Please note:

When the No Surprises Act applies to items and services from an Out-of-Network Provider at a participating facility, you cannot be billed for the difference between the amount charged and the total amount paid by us. The only exception to this would be if an eligible Out-of-Network Provider performing services in a participating facility gives you proper notice in plain language that you will be receiving services from an Out-of-Network Provider and you consent to be balance-billed and to have the amount that you pay determined without reference to the No Surprises Act. Certain providers are not permitted to provide notice and request consent for this purpose. These include items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or nonphysician practitioner; items and services provided by assistant surgeons, hospitalists, and intensivists; diagnostic services, including radiology and laboratory

services; and items and services provided by an Out-of-Network Provider, only if there is no Participating Provider who can furnish such item or service at such facility.

See Also:

Chemical Dependency Treatment earlier in this section.

Mental Health Services later in this section.

Illness or Injury Services

Covered:

- Services or supplies used to treat any bodily disorder, bodily injury, disease, or mental health condition unless specifically addressed elsewhere in this section. This includes pregnancy and complications of pregnancy for a member or spouse. Pregnancy and complications of pregnancy are not covered for a dependent.
- Routine foot care related to the treatment of a metabolic, neurological, or peripheral vascular disease.

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

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

Not Covered:

- Long term acute care services typically provided by a long term acute care facility.
- Pregnancy and complications of pregnancy for a dependent.
- Room and board provided while a patient at an intermediate care facility or similar level of care.
- Services and supplies associated with routine foot care except as described under *Covered*.

Infertility Treatment

Not Covered:

- Services and supplies associated with infertility diagnosis and treatment.
- Services and supplies associated with infertility treatment if the infertility is the result of voluntary sterilization.
- Services and supplies associated with infertility treatment related to the collection or purchase of donor semen (sperm) or oocytes (eggs); freezing and storage of sperm, oocytes, or embryos; surrogate parent services.
- Reversal of a tubal ligation (or its equivalent) or vasectomy.

Elective sterilization benefits are not covered for:

- Expenses incurred by a dependent other than an eligible dependent's spouse;
- More than one sterilization procedure per covered member;
- More than one sterilization procedure per eligible family; or
- Expenses incurred for the purpose of reversing a sterilization procedure.

Inhalation Therapy

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

Maternity Services

Covered: Prenatal care, delivery, and postpartum care, including complications of pregnancy. A complication of pregnancy refers to any maternity-related condition that is not diagnosed and coded as a normal prenatal visit or a normal spontaneous vaginal delivery.

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

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

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

Coverage includes one follow-up postpartum home visit by a registered nurse (R.N.). This nurse must be from a home health agency under contract with Wellmark or employed by the delivering physician.

Not Covered: Maternity services and complications of pregnancy for dependent children.

See Also:

Coverage Change Events, page 53.

Medical and Surgical Supplies and Personal Convenience Items

Covered: Medical supplies and devices such as:

- Dressings and casts.
- Oxygen and equipment needed to administer the oxygen.
- Diabetic equipment and supplies purchased from a covered provider.

Not Covered: Unless otherwise required by law, supplies, equipment, or drugs available for general retail purchase or items used for your personal convenience including, but not limited to:

- Band-aids, gauze, bandages, tape, non-sterile gloves, thermometers, heating pads, cooling devices, cold packs, heating devices, hot water bottles, home enema equipment, sterile water, bed boards, alcohol wipes, or incontinence products;
- Elastic stockings or bandages including trusses, lumbar braces, garter belts, and similar items that can be purchased without a prescription;
- Escalators, elevators, ramps, stair glides, emergency/alert equipment, handrails, heat appliances, improvements made to a member's house or place of business, or adjustments made to vehicles;
- Household supplies including, but not limited to: deluxe/luxury equipment or non-essential features, such as motor-driven chairs or bed, electric stair chairs or elevator chairs, or sitz bath;
- Items not primarily and customarily manufactured to serve a medical purpose or which can be used in the absence of illness or injury including, but not limited to, air conditioners, hot tubs, or swimming pools;
- Items that do not serve a medical purpose or are not needed to serve a medical purpose;
- Rental or purchase of equipment if you are in a facility which provides such equipment;
- Rental or purchase of exercise cycles, physical fitness, exercise and massage equipment, ultraviolet/tanning equipment, or traction devices; and
- Water purifiers, hypo-allergenic pillows, mattresses or waterbeds, whirlpool, spa, air purifiers, humidifiers, dehumidifiers, or light devices.

See Also:

Home/Durable Medical Equipment earlier in this section.

Orthotics (Foot) later in this section.

Prosthetic Devices later in this section.

Mental Health Services

Covered: Treatment for certain psychiatric, psychological, or emotional

conditions as an inpatient or outpatient. Covered facilities for mental health services include licensed and accredited residential treatment facilities and community mental health centers.

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

- The disorder is classified as a mental health condition in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-V) or subsequent revisions, except as otherwise provided in this summary plan description.
- The disorder is listed only as a mental health condition and not dually listed elsewhere in the most current version of *International Classification of Diseases, Clinical Modification* used for diagnosis coding.

Licensed Psychiatric or Mental Health Treatment Program Services. Benefits are available for mental health treatment in the following settings:

- Treatment provided in an office visit, or outpatient setting;
- Treatment provided in an intensive outpatient setting;
- Treatment provided in an outpatient partial hospitalization setting;
- Individual, group, or family therapy provided in a clinically managed low intensity residential treatment setting, also known as supervised living;
- Treatment, including room and board, provided in a clinically managed medium or high intensity residential treatment setting;
- Psychiatric observation;
- Care provided in a psychiatric residential crisis program;
- Care provided in a medically monitored intensive inpatient setting; and
- For inpatient, medically managed acute care for patients whose condition requires the resources of an acute care general hospital or a medically managed inpatient treatment program.

Not Covered:

- Services and supplies associated with gender-affirmation services. You are not covered for management, consultation, counseling, or surgical services for gender-affirmation.
- Services and supplies associated with certain disorders related to early childhood, such as academic underachievement disorder.
- Services and supplies associated with communication disorders, such as stuttering and stammering.
- Services and supplies associated with impulse control disorders.
- Services and supplies associated with conditions that are not pervasive developmental and learning disorders.
- Services and supplies associated with sensitivity, shyness, and social withdrawal disorders.
- Services and supplies associated with sexual disorders.
- Room and board provided while participating in a clinically managed low intensity residential treatment setting, also known as supervised living.
- Recreational activities or therapy, social activities, meals, excursions or other activities not considered clinical treatment, while participating in residential psychiatric treatment programs.

See Also:

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

Motor Vehicles

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

Musculoskeletal Treatment

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

Benefits Maximum:

- **$500** per benefit year for chiropractic services received from Participating and Out-of-Network providers.

Not Covered:

- Manipulations or related procedures to treat musculoskeletal injury or disease performed for maintenance.
- Massage therapy.

Nonmedical or Administrative Services

Not Covered: Such services as telephone consultations, charges for failure to keep scheduled appointments, charges for completion of any form, charges for medical information, recreational therapy and other sensory-type activities, administrative services (such as interpretive services, pre-care assessments, health risk assessments, care management, care coordination, or development of treatment plans) when billed separately, and any services or supplies that are nonmedical.

Nutritional and Dietary Supplements

Covered:

- Nutritional and dietary supplements that cannot be dispensed without a prescription issued by or authorized by a licensed healthcare practitioner and are prescribed by a licensed healthcare practitioner for permanent inborn errors of metabolism, such as PKU.
- Enteral and nutritional therapy only when prescribed feeding is administered through a feeding tube, except for permanent inborn errors of metabolism.

Not Covered: Other prescription and non-prescription nutritional and dietary supplements including, but not limited to:

- Food products.
- Grocery items or food products that are modified for special diets for individuals with inborn errors of metabolism but which can be purchased without a prescription issued by or authorized by a licensed healthcare practitioner, including low protein/low phe grocery items.
- Herbal products.
- Fish oil products.
- Medical foods, except as described under *Covered*.
- Minerals.
- Supplementary vitamin preparations.
- Multivitamins.

Obesity Treatment

Not Covered: Services and supplies associated with obesity treatment.

Occupational Therapy

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

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

Not Covered:

- Occupational therapy supplies.

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

Orthotics (Foot)

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

Benefits Maximum:

- **$300** per benefit year.

Not Covered: Orthopedic shoes or examinations to prescribe or fit such shoes.

See Also:

Home/Durable Medical Equipment earlier in this section.

Prosthetic Devices later in this section.

Physical Therapy

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

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

Not Covered:

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

Physicians and Practitioners

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

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

Audiologists.

Chiropractors.

Doctors of Osteopathy (D.O.).

Licensed Independent Social Workers.

Licensed Mental Health Counselors.

Medical Doctors (M.D.).

Occupational Therapists. This provider is covered only when treating the upper extremities, which means the arms from the shoulders to the fingers.

Optometrists.

Oral Surgeons.

Physical Therapists.

Physician Assistants.

Podiatrists.

Psychologists. Psychologists must have a doctorate degree in psychology with two years' clinical experience and

meet the standards of a national register.

Speech Pathologists.

Benefits Maximum:

- **$500** per benefit year for chiropractic services received from Participating and Out-of-Network providers.

Not Covered:

- Licensed Marriage and Family Therapists.

See Also:

Choosing a Provider, page 33.

Prescription Drugs

Covered:

- When you are an inpatient or outpatient of a facility.
- Any state sales tax associated with the purchase of a covered prescription drug.

Prescription drugs and medicines that may be covered under your medical benefits include:

Drugs and Biologicals. Drugs and biologicals approved by the U.S. Food and Drug Administration. This includes such supplies as serum, vaccine, antitoxin, or antigen used in the prevention or treatment of disease.

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

Take-Home Drugs. Take-home drugs are drugs dispensed and billed by a hospital or other facility for a short-term supply.

Not Covered:

- Antigen therapy.
- Medication Therapy Management (MTM) when billed separately.
- Prescription drugs or pharmacy durable medical equipment devices that are not FDA-approved.
- Insulin.
- Prescription drugs and devices used to treat nicotine dependence.
- Prescription drugs other than as stated earlier in this section.

See Also:

Contraceptives earlier in this section.

Medical and Surgical Supplies and Personal Convenience Items earlier in this section.

Notification Requirements and Care Coordination, page 41.

Preventive Care

Covered: Preventive care such as:

- Breastfeeding support, supplies, and one-on-one lactation consultant services, including counseling and education, provided during pregnancy and/or the duration of breastfeeding received from a provider acting within the scope of their licensure or certification under state law.
- Digital breast tomosynthesis (3D mammogram).
- Gynecological examinations.
- Mammograms.
- Medical evaluations and counseling for nicotine dependence per U.S. Preventive Services Task Force (USPSTF) guidelines.
- Pap smears.
- Physical examinations.
- Preventive items and services including, but not limited to:
  - Items or services with an “A” or “B” rating in the current recommendations of the United States Preventive Services Task Force (USPSTF);
  - Immunizations as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (ACIP);

  - — Preventive care and screenings for infants, children and adolescents provided for in the guidelines supported by the Health Resources and Services Administration (HRSA); and
  - — Preventive care and screenings for women provided for in guidelines supported by the HRSA.
- Well-child care including immunizations.

Benefits Maximum:

- Well-child care until the child reaches age 26.
- **One** routine physical examination per benefit year.
- **One** routine mammogram per benefit year.
- **One** routine gynecological examination per benefit year.
- **One** routine Pap smear per benefit year.

Please note: Physical examination limits do not include items or services with an "A" or "B" rating in the current recommendations of the USPSTF, immunizations as recommended by ACIP, and preventive care and screening guidelines supported by the HRSA, as described under *Covered*.

Not Covered:

- Periodic physicals or health examinations, screening procedures, or immunizations performed solely for school, sports, employment, insurance, licensing, or travel, or other administrative purposes.
- Group lactation consultant services.

See Also:

Hearing Services earlier in this section.

Vision Services later in this section.

Prosthetic Devices

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

Also covered are braces, which are rigid or semi-rigid devices commonly used to support a weak or deformed body part or to restrict or eliminate motion in a diseased or injured part of the body. Braces do not include elastic stockings, elastic bandages, garter belts, arch supports, orthodontic devices, or other similar items.

Not Covered:

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

See Also:

Home/Durable Medical Equipment earlier in this section.

Medical and Surgical Supplies and Personal Convenience Items earlier in this section.

Orthotics (Foot) earlier in this section.

Reconstructive Surgery

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

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

See Also:

Cosmetic Services earlier in this section.

Self-Help Programs

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

Sleep Apnea Treatment

Covered: Obstructive sleep apnea diagnosis and treatments.

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

Social Adjustment

Not Covered: Services or supplies intended to address social adjustment or economic needs that are typically not medical in nature.

Speech Therapy

Covered: Rehabilitative or habilitative speech therapy services when related to a specific illness, injury, or impairment, including speech therapy services for the treatment of autism spectrum disorder, that involve the mechanics of phonation, articulation, or swallowing. Services must be provided by a licensed or certified speech pathologist.

Not Covered:

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

Surgery

Covered. This includes the following:

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

Not Covered:

- Bariatric surgery or any bariatric-related surgery including, but not limited to, panniculectomy or other body contouring procedures.
- Gender-affirming surgery.

See Also:

Dental Services earlier in this section.

Reconstructive Surgery earlier in this section.

Telehealth Services

Covered: You are covered for telehealth services delivered to you by a covered practitioner acting within the scope of his or her license or certification or by a practitioner contracting through Doctor on Demand via real-time, interactive audio-visual technology, web-based mobile device or similar electronic-based communication network, or as otherwise required by Iowa law. Services must be delivered in accordance with applicable law and generally accepted health care practices. Contact Doctor on Demand Customer Service: Via Phone: (800) 997-6196.

Please note: Members can access telehealth services from Doctor on Demand through the Doctor on Demand mobile application or through *myWellmark.com*.

Not Covered: Medical services provided through means other than interactive, real-time audio-visual technology, including, but not limited to, audio-only telephone, electronic mail message, or facsimile transmission.

Temporomandibular Joint Disorder (TMD)

Not Covered: All services or supplies for treatment of temporomandibular joint disorders, myofascial pain syndrome, or craniomandibular dysfunction.

Transplants

Covered:

- Certain bone marrow/stem cell transfers from a living donor.
- Heart.
- Heart and lung.
- Kidney.
- Liver.

- Lung.
- Pancreas.
- Simultaneous pancreas/kidney.
- Small bowel.

You are also covered for the medically necessary expenses of transporting the recipient when the transplant organ for the recipient is available for transplant.

Transplants are subject to care management.

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

Not Covered:

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

See Also:

Ambulance Services earlier in this section.

Care Management, page 45.

Travel or Lodging Costs

Not Covered.

Vision Services

Covered:

- Vision examinations but only when related to an illness or injury.
- Eyeglasses, but only when prescribed as the result of cataract extraction.
- Contact lenses and associated lens fitting, but only when prescribed as the result of cataract extraction or when the underlying diagnosis is a corneal injury or corneal disease.

Not Covered:

- Surgery and services to diagnose or correct a refractive error, including intraocular lenses and laser vision correction surgery (e.g., LASIK surgery).
- Eyeglasses, contact lenses, or the examination for prescribing or fitting of eyeglasses or contact lenses, except when prescribed as the result of cataract extraction or when the underlying diagnosis is a corneal injury or disease.
- Routine vision examinations.

Wigs or Hairpieces

Not Covered.

X-ray and Laboratory Services

Covered: Tests, screenings, imagings, and evaluation procedures as identified in the American Medical Association's Current Procedural Terminology (CPT) manual, Standard Edition, under *Radiology Guidelines* and *Pathology and Laboratory Guidelines*.

See Also:

Preventive Care earlier in this section.

4. General Conditions of Coverage, Exclusions, and Limitations

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

Conditions of Coverage

Medically Necessary
A key general condition in order for you to receive benefits is that the service, supply, device, or drug must be medically necessary. Even a service, supply, device, or drug listed as otherwise covered in *Details - Covered and Not Covered* may be excluded if it is not medically necessary in the circumstances. Wellmark determines whether a service, supply, device, or drug is medically necessary, and that decision is final and conclusive. Wellmark's medically necessary analysis and determinations apply to any service, supply, device, or drug including, but not limited to, medical, mental health, and chemical dependency treatment, as appropriate. Even though a provider may recommend a service or supply, it may not be medically necessary.

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

- Provided in accordance with generally accepted standards of medical practice. Generally accepted standards of medical practice are based on:
  - Nationally recognized utilization management standards as utilized by Wellmark; or
  - Wellmark's published Medical and Drug Policies as determined applicable by Wellmark; or
  - Credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community; or
  - Physician Specialty Society recommendations and the views of physicians practicing in the relevant clinical area.
- Clinically appropriate in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease,
- Not provided primarily for the convenience of the patient, physician, or other health care provider, and
- Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the illness, injury or disease.

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

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

- You receive the services from an Out-of-Network Provider; or
- You receive the services from a PPO or Participating provider in the Wellmark service area and:
  - The provider informs you in writing before rendering the services that Wellmark determined the services to be not medically necessary; and
  - The provider gives you a written estimate of the cost for such services

and you agree in writing, before receiving the services, to assume the payment responsibility.

If you do not receive such a written notice, and do not agree in writing to assume the payment responsibility for services that Wellmark determined are not medically necessary, the PPO or Participating provider is responsible for these amounts.

- You are also responsible for the cost if you receive services from a provider outside of the Wellmark service area that Wellmark determines to be not medically necessary. This is true even if the provider does not give you any written notice before the services are rendered.

Member Eligibility
Another general condition of coverage is that the person who receives services must meet requirements for member eligibility.

General Exclusions

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

Investigational or Experimental
You are not covered for a service, supply, device, biological product, or drug that is investigational or experimental. You are also not covered for any care or treatments related to the use of a service, supply, device, biological product, or drug that is investigational or experimental. A treatment is considered investigational or experimental when it has progressed to limited human application but has not achieved recognition as being proven effective in clinical medicine. Our analysis of whether a service, supply, device, biological product, or drug is considered investigational or experimental is applied to medical, surgical, mental health, and chemical dependency treatment services, as applicable.

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

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

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

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

- You receive the services from an Out-of-Network Provider; or
- You receive the services from a PPO or Participating provider in the Wellmark service area and:
  - The provider informs you in writing before rendering the services that Wellmark determined the services to be investigational or experimental; and
  - The provider gives you a written estimate of the cost for such services

and you agree in writing, before receiving the services, to assume the payment responsibility.

If you do not receive such a written notice, and do not agree in writing to assume the payment responsibility for services that Wellmark determined to be investigational or experimental, the PPO or Participating provider is responsible for these amounts.

- You are also responsible for the cost if you receive services from a provider outside of the Wellmark service area that Wellmark determines to be investigational or experimental. This is true even if the provider does not give you any written notice before the services are rendered.

See Also:

Clinical Trials, page 13.

Complications of a Noncovered Service

You are not covered for a complication resulting from a noncovered service, supply, device, or drug. However, this exclusion does not apply to the treatment of complications resulting from a noncovered abortion for a member or spouse (a dependent child is excluded from this exception).

Nonmedical or Administrative Services

You are not covered for telephone consultations, charges for failure to keep scheduled appointments, charges for completion of any form, charges for medical information, recreational therapy and other sensory-type activities, administrative services (such as interpretive services, pre-care assessments, health risk assessments, care management, care coordination, or development of treatment plans) when billed separately, and any services or supplies that are nonmedical.

Provider Is Family Member

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

Covered by Other Programs or Laws

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

Workers' Compensation

You are not covered for services or supplies for which we learn or are notified by you, your provider, or our vendor that such services or supplies are related to a work related illness or injury, including services or supplies applied toward satisfaction of any deductible under your employer's workers' compensation coverage. You are also not covered for any services or supplies that could have been compensated under workers' compensation laws if:

- you did not comply with the legal requirements relating to notice of injury, timely filing of claims, and medical treatment authorization; or
- you rejected workers' compensation coverage.

The exclusion for services or supplies related to work related illness or injury does not exclude coverage for such illness or injury if you are exempt from coverage under Iowa's workers' compensation statutes pursuant to Iowa Code Section 85.1 (1)-(4), unless you or your employer has elected or obtained workers' compensation coverage as provided in Iowa Code Section 85.1(6).

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

Wellmark Medical and Drug Policies
Wellmark maintains Medical and Drug Policies that are applied in conjunction with other resources to determine whether a specific service, supply, device, biological product, or drug is a covered service under the terms of this summary plan description. These policies are hereby incorporated into this summary plan description. You may access these policies along with supporting information and selected medical references through our website, *Wellmark.com*.

Benefit Limitations

Benefit limitations refer to amounts for which you are responsible under this group health plan. These amounts are not credited toward your out-of-pocket maximum. In addition to the exclusions and conditions described earlier, the following are examples of benefit limitations under this group health plan:

- A service or supply that is not covered under this group health plan is your responsibility.
- If a covered service or supply reaches a 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 11.
- If you do not obtain precertification for certain medical services, benefits can be denied. You are responsible for benefit denials only if you are responsible (not your provider) for notification. A PPO Provider in Iowa or South Dakota will handle notification requirements for you. If you see a PPO Provider outside Iowa or South Dakota, you are responsible for notification requirements. See *Notification Requirements and Care Coordination*, page 41.
- If you do not obtain prior approval for certain medical services, benefits will be denied on the basis that you did not obtain prior approval. Upon receiving an Explanation of Benefits (EOB) indicating a denial of benefits for failure to request prior approval, you will have the opportunity to appeal (see the *Appeals* section) and provide us with medical information for our consideration in determining whether the services were medically necessary and a benefit under your medical benefits. Upon review, if we determine the service was medically necessary and a benefit under your medical benefits, benefits for that service will be provided according to the terms of your medical benefits.

  You are responsible for these benefit denials only if you are responsible (not your provider) for notification. A PPO Provider in Iowa or South Dakota will handle notification requirements for you. If you see a PPO Provider outside Iowa or South Dakota, you are responsible for notification requirements. See *Notification Requirements and Care Coordination*, page 41.
- The type of provider you choose can affect your benefits and what you pay. See *Choosing a Provider*, page 33, and *Factors Affecting What You Pay*, page 47. 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 an Out-of-Network Provider.

5. Choosing a Provider

Provider Network

Under the medical benefits of this plan, your network of providers consists of PPO and Participating providers. All other providers are Out-of-Network Providers. Which provider type you choose will affect what you pay.

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

Non-PPO providers are either Participating or Out-of-Network. If you are unable to utilize a PPO Provider, it is usually to your advantage to visit what we call a *Participating Provider*. Participating Providers participate with a Blue Cross and/or Blue Shield Plan in another state or service area, but not with a PPO.

Other providers are considered Out-of-Network, and you will usually pay the most for services you receive from them.

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

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

Providers are independent contractors and are not agents or employees of Wellmark Blue Cross and Blue Shield of Iowa. For types of providers that may be covered under your medical benefits, see *Hospitals and Facilities*, page 18 and *Physicians and Practitioners*, page 23.

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

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

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

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

Services Outside the Wellmark Service Area

BlueCard Program

This program ensures that members of any Blue Plan have access to the advantages of PPO Providers throughout the United States. Participating Providers have a contractual agreement with the Blue Cross and/or Blue Shield Plan in their home state ("Host Blue"). The Host Blue is responsible for contracting with and generally handling all interactions with its Participating Providers.

The BlueCard Program is one of the advantages of your coverage with Wellmark Blue Cross and Blue Shield of Iowa. It provides conveniences and benefits outside the Wellmark service area similar to those you would have within our service area when you obtain covered medical services from a PPO Provider. Always carry your ID card (or BlueCard) and present it to your provider when you receive care. Information on it, especially the ID number, is required to process your claims correctly.

PPO Providers may not be available in some states. In this case, when you receive covered services from a non-PPO provider (i.e., a Participating or Out-of-Network provider), you will receive many of the same advantages as when you receive covered services from a PPO Provider. However, because we do not have contracts with Out-of-Network Providers and they may not accept our payment arrangements, you are responsible for any difference between the amount charged and our amount paid for a covered service. An exception to this is when the No Surprises Act applies to your items or services. In that case, the amount you pay will be determined in accordance with the Act. See *Payment Details*, page 4. Additionally, you cannot be billed for the difference between the amount charged and the total amount paid by us. The only exception to this would be if an eligible Out-of-Network Provider performing services in a participating facility gives you proper notice in plain language that you will be receiving services from an Out-of-Network Provider and you consent to be balance-billed and to have the amount that you pay determined without reference to the No Surprises Act. Certain providers are not permitted to provide notice and request consent for this purpose. These include items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or nonphysician practitioner; items and services provided by assistant surgeons, hospitalists, and intensivists; diagnostic services, including radiology and laboratory services; and items and services provided by an Out-of-Network Provider, only if there is no Participating

Provider who can furnish such item or service at such facility.

PPO Providers contract with the Blue Cross and/or Blue Shield preferred provider organization (PPO) in their home state.

When you receive covered services from PPO or Participating providers outside the Wellmark service area, all of the following statements are true:

- Claims are filed for you.
- These providers agree to accept payment arrangements or negotiated prices of the Blue Cross and/or Blue Shield Plan with which the provider contracts. These payment arrangements may result in savings.
- The group health plan payment is sent directly to the providers.
- Wellmark requires claims to be filed within 365 days following the date of service (or 365 days from date of discharge for inpatient claims). However, if the PPO or Participating provider's contract with the Host Blue has a requirement that a claim be filed in a timeframe exceeding 365 days following the date of service or date of discharge for inpatient claims, Wellmark will process the claim according to the Host Blue's contractual filing requirement. If you receive services from an Out-of-Network Provider, the claim has to be filed within 365 days following the date of service or date of discharge for inpatient claims.

Typically, when you receive covered services from PPO or Participating providers outside the Wellmark service area, you are responsible for notification requirements. See *Notification Requirements and Care Coordination*, page 41. However, if you are admitted to a BlueCard facility outside the Wellmark service area, any PPO or Participating provider should handle notification requirements for you.

We have a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you access healthcare services outside the Wellmark service area, the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described in the following paragraphs.

When you receive care outside of our service area, you will receive it from one of two kinds of providers. Most providers ("Participating Providers") contract with the local Blue Cross and/or Blue Shield Plan in that geographic area ("Host Blue"). Some providers ("Out-of-Network Providers") don't contract with the Host Blue. In the following paragraphs we explain how we pay both kinds of providers.

Inter-Plan Arrangements Eligibility – Claim Types

All claim types are eligible to be processed through Inter-Plan Arrangements, as described previously, except for all dental care benefits (except when paid as medical benefits), and those prescription drug benefits or vision care benefits that may be administered by a third party contracted by us to provide the specific service or services.

BlueCard® Program

Under the BlueCard® Program, when you receive covered services within the geographic area served by a Host Blue, we will remain responsible for doing what we agreed to in the contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its Participating Providers.

When you receive covered services outside Wellmark's service area and the claim is processed through the BlueCard Program, the amount you pay for covered services is calculated based on the lower of:

- The billed charges for covered services; or

- The negotiated price that the Host Blue makes available to us.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare provider or provider group that may include types of settlements, incentive payments and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of modifications of past pricing of claims, as noted previously. However, such adjustments will not affect the price we have used for your claim because they will not be applied after a claim has already been paid.

Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

Federal or state laws or regulations may require a surcharge, tax, or other fee that applies to insured accounts. If applicable, we will include any such surcharge, tax, or other fee as part of the claim charge passed on to you.

Out-of-Network Providers Outside the Wellmark Service Area

Your Liability Calculation. When covered services are provided outside of our service area by Out-of-Network Providers, the amount you pay for such services will normally be based on either the Host Blue's Out-of-Network Provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be responsible for the difference between the amount that the Out-of-Network Provider bills and the payment we will make for the covered services as set forth in this summary plan description.

An exception to this is when the No Surprises Act applies to your items or services. In that case, the amount you pay will be determined in accordance with the Act. See *Payment Details*, page 4. Additionally, you cannot be billed for the difference between the amount charged and the total amount paid by us. The only exception to this would be if an eligible Out-of-Network Provider performing services in a participating facility gives you proper notice in plain language that you will be receiving services from an Out-of-Network Provider and you consent to be balance-billed and to have the amount that you pay determined without reference to the No Surprises Act. Certain providers are not permitted to provide notice and request consent for this purpose. These include items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or nonphysician practitioner; items and services provided by assistant surgeons, hospitalists, and intensivists; diagnostic services, including radiology and laboratory services; and items and services provided by an Out-of-Network Provider, only if there is no Participating Provider who can furnish such item or service at such facility.

In certain situations, we may use other payment methods, such as billed charges for covered services, the payment we would make if the healthcare services had been obtained within our service area, or a special negotiated payment to determine the amount we will pay for services provided by Out-of-Network Providers. In these situations, you may be liable for the difference between the amount that the Out-of-Network Provider bills and the payment we will make for the covered services as set forth in this summary plan description.

Care in a Foreign Country

For covered services you receive in a country other than the United States, payment level assumes the provider category is Out-of-Network except for

services received from providers that participate with Blue Cross Blue Shield Global Core.

Blue Cross Blue Shield Global® Core Program

If you are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter "BlueCard service area"), you may be able to take advantage of the Blue Cross Blue Shield Global Core Program when accessing covered services. The Blue Cross Blue Shield Global Core Program is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although the Blue Cross Blue Shield Global Core Program assists you with accessing a network of inpatient, outpatient, and professional providers, the network is not served by a Host Blue. As such, when you receive care from providers outside the BlueCard service area, you will typically have to pay the providers and submit the claims yourself to obtain reimbursement for these services.

If you need medical assistance services (including locating a doctor or hospital) outside the BlueCard service area, you should call the Blue Cross Blue Shield Global Core Service Center at **800-810-BLUE** (2583) or call collect at **804-673-1177**, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

Inpatient Services. In most cases, if you contact the Blue Cross Blue Shield Global Core Service Center for assistance, hospitals will not require you to pay for covered inpatient services, except for your deductibles, coinsurance, etc. In such cases, the hospital will submit your claims to the Blue Cross Blue Shield Global Core Service Center to begin claims processing. However, if you paid in full at the time of service, you must submit a claim to receive reimbursement for covered services. **You must contact us to obtain precertification for non-emergency inpatient services.**

Outpatient Services. Physicians, urgent care centers and other outpatient providers located outside the BlueCard service area will typically require you to pay in full at the time of service. You must submit a claim to obtain reimbursement for covered services. See *Claims*, page 53.

Submitting a Blue Cross Blue Shield Global Core Claim

When you pay for covered services outside the BlueCard service area, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a Blue Cross Blue Shield Global Core International claim form and send the claim form with the provider's itemized bill(s) to the Blue Cross Blue Shield Global Core Service Center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from us, the Blue Cross Blue Shield Global Core Service Center, or online at *www.bcbsglobalcore.com*. If you need assistance with your claim submission, you should call the Blue Cross Blue Shield Global Core Service Center at **800-810-BLUE** (2583) or call collect at **804-673-1177**, 24 hours a day, seven days a week.

Whenever possible, before receiving services outside the Wellmark service area, you should ask the provider if he or she participates with a Blue Cross and/or Blue Shield Plan in that state. To locate PPO Providers in any state, call **800-810-BLUE**, or visit *www.bcbs.com*.

Iowa and South Dakota comprise the Wellmark service area.

Laboratory services. You may have laboratory specimens or samples collected by a PPO Provider and those laboratory specimens may be sent to another laboratory services provider for processing or testing. If that laboratory services provider does not have a contractual

relationship with the Blue Plan where the specimen was drawn,* that provider will be considered an Out-of-Network Provider and you will be responsible for any applicable Out-of-Network Provider payment obligations and you may also be responsible for any difference between the amount charged and our amount paid for the covered service.

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

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

If you purchase or rent home/durable medical equipment and have that equipment shipped to a service area of a Blue Plan that does not have a contractual relationship with the home/durable medical equipment provider, that provider will be considered Out-of-Network and you will be responsible for any applicable Out-of-Network Provider payment obligations and you may also be responsible for any difference between the amount charged and our amount paid for the covered service. This includes situations where you purchase or rent home/durable medical equipment and have the equipment shipped to you in Wellmark's service area, when Wellmark does not have a contractual relationship with the home/durable medical equipment provider.

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

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

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

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

See *Out-of-Network Providers,* page 49.

Continuity of Care

If you are a Continuing Care Patient

- undergoing a course of treatment for a serious or complex condition,

- undergoing a course of institutional or inpatient care,
- scheduled to undergo nonelective surgery, including postoperative care with respect to such surgery,
- pregnant and undergoing a course of treatment for the pregnancy, including postpartum care related to childbirth and delivery, or
- receiving treatment for a terminal illness and, with respect to the provider or facility providing such treatment:
  - the network agreement between the provider or facility and Wellmark is terminated; or
  - benefits provided under this plan with respect to such provider or facility are terminated because of a change in the terms of the participation of such provider or facility in such plan or coverage;

then you may elect to continue to have benefits provided under this plan under the same terms and conditions as would have applied and with respect to such items and services as would have been covered under the plan as if the termination resulting in out-of-network status had not occurred. This Continuity of Care applies only with respect to the course of treatment furnished by such provider or facility relating to the condition affecting an individual's status as a Continuing Care Patient. Claims for treatment of the condition from the provider or facility will be considered in-network claims until the earlier of (i) the date you are no longer considered a Continuing Care Patient, or (ii) the end of a 90 day period beginning on the date you have been notified of your opportunity to elect transitional care.

In order to elect transitional care as a Continuing Care Patient, you may respond to the letter Wellmark sends you, or you or your provider may call us at **800-552-3993**.

6. Notification Requirements and Care Coordination

Many services including, but not limited to, medical, surgical, mental health, and chemical dependency treatment services, require a notification to us or a review by us. If you do not follow notification requirements properly, you may have to pay for services yourself, so the information in this section is critical. For a complete list of services subject to notification or review, visit *Wellmark.com* or call the Customer Service number on your ID card.

Providers and Notification Requirements
PPO or Participating providers in Iowa and South Dakota should handle notification requirements for you. If you are admitted to a PPO or Participating facility outside Iowa or South Dakota, the PPO or Participating provider should handle notification requirements for you.

If you receive any other covered services (i.e., services unrelated to an inpatient admission) from a PPO or Participating provider outside Iowa or South Dakota, or if you see an Out-of-Network Provider, you or someone acting on your behalf is responsible for notification requirements.

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

You or your authorized representative, if you have designated one, may appeal a denial of benefits resulting from these notification requirements and care coordination programs. See *Appeals*, page 63. Also see *Authorized Representative*, page 71.

Precertification

Purpose	Precertification helps determine whether a service or admission to a facility is medically necessary. Precertification is required; however, it does not apply to maternity or emergency services.
Applies to	For a complete list of the services subject to precertification, visit *Wellmark.com* or call the Customer Service number on your ID card.
Person Responsible for Obtaining Precertification	**You** or someone acting on your behalf is responsible for obtaining precertification if: ■ You receive services subject to precertification from an Out-of-Network Provider; or ■ You receive non-inpatient services subject to precertification from a PPO or Participating provider outside Iowa or South Dakota; **Your Provider** should obtain precertification for you if: ■ You receive services subject to precertification from a PPO Provider in Iowa or South Dakota; or ■ You receive inpatient services subject to precertification from a PPO or Participating provider outside Iowa or South Dakota. **Please note:** If you are ever in doubt whether precertification has been obtained, call the Customer Service number on your ID card.

Process	When you, instead of your provider, are responsible for precertification, call the phone number on your ID card before receiving services. Wellmark will respond to a precertification request within: ■ 72 hours in a medically urgent situation; ■ 15 days in a non-medically urgent situation. Precertification requests must include supporting clinical information to determine medical necessity of the service or admission. After you receive the service(s), Wellmark may review the related medical records to confirm the records document the services subject to the approved precertification request. The medical records also must support the level of service billed and document that the services have been provided by the appropriate personnel with the appropriate level of supervision.
Importance	If you choose to receive services subject to precertification, you will be responsible for the charges as follows: ■ If you receive services subject to precertification from an Out-of-Network Provider and we determine that the procedure was not medically necessary you will be responsible for the full charge. ■ Except for hospital inpatient services and outpatient surgeries, failure to obtain precertification will not result in reduced or denied benefits. Denied benefits that result from failure to follow notification requirements are not credited toward your out-of-pocket maximum. See *What You Pay*, page 3.

Notification

Purpose	Notification of most facility admissions and certain services helps us identify and initiate discharge planning or care coordination. Notification is required.
Applies to	For a complete list of the services subject to notification, visit *Wellmark.com* or call the Customer Service number on your ID card.
Person Responsible	PPO Providers in the states of Iowa and South Dakota perform notification for you. However, you or someone acting on your behalf is responsible for notification if: ■ You receive services subject to notification from a provider outside Iowa or South Dakota; ■ You receive services subject to notification from a Participating or Out-of-Network provider.
Process	When you, instead of your provider, are responsible for notification, call the phone number on your ID card before receiving services, except when you are unable to do so due to a medical emergency. In the case of an emergency admission, you must notify us within one business day of the admission or the receipt of services or as soon as reasonably possible thereafter.

Prior Approval

Purpose	Prior approval helps determine whether a proposed treatment plan is medically necessary and a benefit under your medical benefits. Prior approval is required.
Applies to	For a complete list of the services subject to prior approval, visit *Wellmark.com* or call the Customer Service number on your ID card.
Person Responsible for Obtaining Prior Approval	**You** or someone acting on your behalf is responsible for obtaining prior approval if: ■ You receive services subject to prior approval from an Out-of-Network Provider; or ■ You receive non-inpatient services subject to prior approval from a PPO or Participating provider outside Iowa or South Dakota. **Your Provider** should obtain prior approval for you if: ■ You receive services subject to prior approval from a PPO Provider in Iowa or South Dakota; or ■ You receive inpatient services subject to prior approval from a PPO or Participating provider outside Iowa or South Dakota. **Please note:** If you are ever in doubt whether prior approval has been obtained, call the Customer Service number on your ID card.
Process	When you, instead of your provider, are responsible for requesting prior approval, call the number on your ID card to obtain a prior approval form and ask the provider to help you complete the form. Wellmark will determine whether the requested service is medically necessary and eligible for benefits based on the written information submitted to us. We will respond to a prior approval request in writing to you and your provider within: ■ 72 hours in a medically urgent situation. ■ 15 days in a non-medically urgent situation. Prior approval requests must include supporting clinical information to determine medical necessity of the services or supplies.

Importance	If your request is approved, the service is covered provided other contractual requirements, such as member eligibility and benefits maximums, are observed. If your request is denied, the service is not covered, and you will receive a notice with the reasons for denial. If you do not request prior approval for a service, the benefit for that service will be denied on the basis that you did not request prior approval. Upon receiving an Explanation of Benefits (EOB) indicating a denial of benefits for failure to request prior approval, you will have the opportunity to appeal (see the *Appeals* section) and provide us with medical information for our consideration in determining whether the services were medically necessary and a benefit under your medical benefits. Upon review, if we determine the service was medically necessary and a benefit under your medical benefits, the benefit for that service will be provided according to the terms of your medical benefits. Approved services are eligible for benefits for a limited time. Approval is based on the medical benefits in effect and the information we had as of the approval date. If your coverage changes for any reason (for example, because of a new job or new medical benefits), an approval may not be valid. If your coverage changes before the approved service is performed, a new approval is recommended. **Note:** When prior approval is required, and an admission to a facility is required for that service, the admission also may be subject to notification or precertification. See *Precertification* and *Notification* earlier in this section.

Concurrent Review

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

Care Management

Purpose	Care management is intended to identify and assist members with the most severe illnesses or injuries by collaborating with members, members' families, and providers to develop individualized care plans.
Applies to	A wide group of members including those who have experienced potentially preventable emergency room visits; hospital admissions/readmissions; those with catastrophic or high cost health care needs; those with potential long term illnesses; and those newly diagnosed with health conditions requiring lifetime management. Examples where care management might be appropriate include but are not limited to: Brain or Spinal Cord Injuries Cystic Fibrosis Degenerative Muscle Disorders Hemophilia Pregnancy (high risk) Transplants
Person Responsible	You, your physician, and the health care facility can work with Wellmark's care managers. Wellmark may initiate a request for care management.
Process	Members are identified and referred to the Care Management program through Customer Service and claims information, referrals from providers or family members, and self-referrals from members.
Importance	Care management is intended to identify and coordinate appropriate care and care alternatives including reviewing medical necessity; negotiating care and services; identifying barriers to care including contract limitations and evaluation of solutions outside the group health plan; assisting the member and family to identify appropriate community-based resources or government programs; and assisting members in the transition of care when there is a change in coverage.

7. Factors Affecting What You Pay

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

Benefit Year

A benefit year is 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.

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

The benefit year is important for calculating:

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

How Coinsurance is Calculated

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

PPO Providers in the Wellmark Service Area and Out-of-Network Providers

Coinsurance is calculated using the payment arrangement amount after the following amounts (if applicable) are subtracted from it:

- Deductible.
- Amounts representing any general exclusions and conditions. See *General Conditions of Coverage, Exclusions, and Limitations*, page 29.

The No Surprises Act may impact deductible, coinsurance, and out-of-pocket maximum calculations. See *Payment Details*, page 4.

PPO and Participating Providers Outside the Wellmark Service Area

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

- The amount charged for the covered service, or
- The negotiated price that the Host Blue makes available to Wellmark after the following amounts (if applicable) are subtracted from it:
  - Deductible.
  - Amounts representing any general exclusions and conditions. See *General Conditions of Coverage,*

Exclusions, and Limitations, page 29.

Often, the negotiated price will be a simple discount that reflects an actual price the local Host Blue paid to your provider. Sometimes, the negotiated price is an estimated price that takes into account special arrangements with your healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, the negotiated price may be an average price based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price. Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or under-estimation of modifications of past pricing for the types of transaction modifications noted previously. However, such adjustments will not affect the price we use for your claim because they will not be applied retroactively to claims already paid.

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

- Deductible.
- Amounts representing any general exclusions and conditions. See *General Conditions of Coverage, Exclusions, and Limitations*, page 29.

Laws in a small number of states may require the Host Blue Plan to add a surcharge to your calculation. If any state laws mandate other liability calculation methods, including a surcharge, Wellmark will calculate your payment obligation for any covered services according to applicable law. For more information, see *BlueCard Program*, page 34.

The No Surprises Act may impact deductible, coinsurance, and out-of-pocket maximum calculations. See *Payment Details*, page 4.

Provider Network

Under the medical benefits of this plan, your network of providers consists of PPO and Participating providers. All other providers are Out-of-Network Providers.

PPO Providers

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

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

Participating Providers

Wellmark and Blue Cross and/or Blue Shield Plans have contracting relationships with Participating Providers. When you receive services from Participating Providers:

- The Participating payment obligation amounts may be waived or may be less than the Out-of-Network amounts for certain covered services. See *Waived Payment Obligations*, page 5.
- These providers agree to accept Wellmark's payment arrangements, or payment arrangements or negotiated prices of the Blue Cross and/or Blue Shield Plan with which the provider contracts. These payment arrangements may result in savings.
- The health plan payment is sent directly to the provider.

Out-of-Network Providers

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

- The following is true unless the No Surprises Act applies:

  You are responsible for any difference between the amount charged and our payment for a covered service. In the case of services received outside Iowa or South Dakota, our maximum payment for services by an Out-of-Network Provider will generally be based on either the Host Blue's Out-of-Network Provider local payment or the pricing arrangements required by applicable state law. In certain situations, we may use other payment bases, such as the amount charged for a covered service, the payment we would make if the services had been obtained within Iowa or South Dakota, or a special negotiated payment, as permitted under Inter-Plan Programs policies, to determine the amount we will pay for services you receive from Out-of-Network Providers. See *Services Outside the Wellmark Service Area,* page 34. However, when you receive services in an in-network facility and are provided covered services by an Out-of-Network ancillary provider, in-network cost-share will be applied and accumulate toward the out-of-pocket maximum. For this purpose, ancillary providers include pathologists, emergency room physicians, anesthesiologists, radiologists, or hospitalists. Because we do not have contracts with Out-of-Network Providers and they may not accept our payment arrangements, you will still be responsible for any difference between the billed charge and our settlement amount for the services from the Out-of-Network ancillary provider unless the No Surprises Act applies.
- Wellmark does not make claim payments directly to these providers, and you are responsible for ensuring that your provider is paid in full, unless the No Surprises Act applies, in which case Wellmark will pay the Out-of-Network Provider directly.
- The group health plan payment for Out-of-Network hospitals, M.D.s, and D.O.s in Iowa is made payable to the provider, but the check is sent to you, and you are responsible for forwarding the check to the provider (plus any billed balance you may owe), unless the No Surprises Act applies, in which case Wellmark will pay the Out-of-Network Provider directly.
- When the No Surprises Act applies to your items or services, you cannot be billed for the difference between the amount charged and the total amount paid by us. The only exception to this would be if an eligible Out-of-Network Provider performing services in a participating facility gives you proper notice in plain language that you will be receiving services from an Out-of-Network Provider and you consent to be balance-billed and to have the amount that you pay determined without reference to the No Surprises Act. Certain providers are not permitted to provide notice and request consent for this purpose. These include items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or nonphysician practitioner; items and services provided by assistant surgeons, hospitalists, and intensivists; diagnostic services, including radiology and laboratory services; and items and services provided by an Out-of-Network Provider, only if there is no Participating Provider who can furnish such item or service at such facility.

Amount Charged and Maximum Allowable Fee

Amount Charged

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

Maximum Allowable Fee

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

Payment Arrangements

Payment Arrangement Savings

Wellmark has contracting relationships with PPO Providers. We use different methods to determine payment arrangements, including negotiated fees. These payment arrangements usually result in savings.

The savings from payment arrangements and other important amounts will appear on your Explanation of Benefits statement as follows:

- *Network Savings*, which reflects the amount you save on a claim by receiving services from a Participating or PPO provider. For the majority of services, the savings reflects the actual amount you save on a claim. However, depending on many factors, the amount we pay a provider could be different from the covered charge. Regardless of the amount we pay a Participating or PPO provider, your payment responsibility will always be based on the lesser of the covered charge or the maximum allowable fee.
- *Amount Not Covered*, which reflects the portion of provider charges not covered under your health benefits and for which you may be responsible. This amount may include services or supplies not covered; amounts in excess of a benefit maximum, benefit year maximum, or lifetime benefits maximum; denials for failure to follow a required precertification; and the difference between the amount charged and the maximum allowable fee for services from an Out-of-Network Provider. For general exclusions and examples of benefit limitations, see *General Conditions of Coverage, Exclusions, and Limitations*, page 29.
- *Amount Paid by Health Plan*, which reflects our payment responsibility to a provider or to you. We determine this amount by subtracting the following amounts (if applicable) from the amount charged:
  - Deductible.
  - Coinsurance.
  - Amounts representing any general exclusions and conditions.
  - Network savings.

Payment Method for Services

When you receive a covered service or services that result in multiple claims, we will calculate your payment obligations based on the order in which we process the claims.

Provider Payment Arrangements

Provider payment arrangements are calculated using industry methods including, but not limited to, fee schedules, per diems, percentage of charge, capitation, or episodes of care. Some provider payment arrangements may include an amount payable to the provider based on the provider's performance. Performance-based amounts that are not distributed are not allocated to your specific group or to your specific claims and are not considered when determining any amounts you may owe. We reserve the right to change the methodology we use to calculate payment arrangements based on industry practice or business need. PPO and Participating providers agree to accept our payment arrangements as full settlement for providing covered services,

except to the extent of any amounts you may owe.

8. 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 and PPO providers file claims for you.

Wellmark must receive claims within 365 days following the date of service of the claim (or 365 days from date of discharge for inpatient claims) or if you have other coverage that has primary responsibility for payment then within 365 days of the date of the other carrier's explanation of benefits. If you receive services outside of Wellmark's service area, Wellmark must receive the claim within 365 days following the date of service (or 365 days from date of discharge for inpatient claims) or within the filing requirement in the contractual agreement between the Participating Provider and the Host Blue. If you receive services from an Out-of-Network Provider, the claim has to be filed within 365 days following the date of service or date of discharge for inpatient claims.

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.

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

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

- Description of each service.

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

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

3. Sign the Claim Form

4. Submit the Claim

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

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

Claims for Services Received Outside the United States. Send the claim to the address printed on the claim form.

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 57.

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

Request for Benefit Exception Review

If you have received an adverse benefit determination that denies or reduces benefits or fails to provide payment in whole or in part for any of the following services, when recommended by your treating provider as medically necessary, you or an individual acting as your authorized representative may request a benefit exception review.

Services subject to this exception process:

- For a woman who previously has had breast cancer, ovarian cancer, or other cancer, but who has not been diagnosed with BRCA-related cancer, appropriate

preventive screening, genetic counseling, and genetic testing.

- FDA-approved or FDA-cleared contraceptive items or services prescribed by your health care provider based upon a specific determination of medical necessity for you.
- For transgender individuals, sex-specific preventive care services (e.g., mammograms and Pap smears) that your attending provider has determined are medically appropriate.
- For dependent children, certain well-woman preventive care services that the attending provider determined are age- and developmentally-appropriate.
- Anesthesia services in connection with a preventive colonoscopy when your attending provider determined that anesthesia would be medically appropriate.
- A required consultation prior to a screening colonoscopy, if your attending provider determined that the pre-procedure consultation would be medically appropriate for you.
- If you received pathology services from an in-network provider related to a preventive colonoscopy screening for which you were responsible for a portion of the cost, such as a deductible, copayment or coinsurance.
- Certain immunizations that ACIP recommends for specified individuals (rather than for routine use for an entire population), when prescribed by your health care provider consistent with the ACIP recommendations.
- FDA-approved intrauterine devices and implants, if prescribed by your health care provider.

You may request a benefit exception review orally or in writing by submitting your request to the address listed in the *Appeals* section. To be considered, your request must include supporting medical record documentation and a letter or statement from your treating provider that the services or supplies were medically necessary and your treating provider's reason(s) for their determination that the services or supplies were medically necessary.

Your request will be addressed within the timeframes outlined in the *Appeals* section based upon whether your request is a medically urgent or non-medically urgent matter.

9. 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 or PPO provider will forward your coverage information to us. If you see an Out-of-Network Provider, you are responsible for informing us about your other coverage.

Claim Filing

If you know that your other coverage has primary responsibility for payment, after you receive services, a claim should be submitted to your other insurance carrier first. If that claim is processed with an unpaid balance for benefits eligible under this group health plan, you or your provider should submit a claim to us and attach the other carrier's explanation of benefit payment within 365 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.
- If the preceding rules do not determine the order of benefits and if the plans cannot agree on the order of benefits within 30 calendar days after the plans have received all information needed to pay the claim, the plans will pay the claim in equal shares and determine their relative liabilities following payment. However, we will not pay more than we would have paid had this plan been primary.

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.
- For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the plan that covered the dependent for the longer period of time is the primary plan. If the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined, as applicable, as outlined in the first bullet of this *Dependent Children* section, to the dependent child's parent or parents and the dependent's spouse.
- If the preceding rules do not determine the order of benefits and if the plans cannot agree on the order of benefits within 30 calendar days after the plans have received all information needed to pay the claim, the plans will pay the claim in equal shares and determine their relative liabilities following payment. However, we will not pay more than we would have paid had this plan been primary.

Coordination with Noncomplying Plans

If you have coverage with another plan that is excess or always secondary or that does not comply with the preceding rules of coordination, we may coordinate benefits on the following basis:

- If this is the primary plan, we will pay its benefits first.
- If this is the secondary plan, we will pay benefits first, but the amount of benefits will be determined as if this plan were secondary. Our payment will be limited

to the amount we would have paid had this plan been primary.

- If the noncomplying plan does not provide information needed to determine benefits, we will assume that the benefits of the noncomplying plan are identical to this plan and will administer benefits accordingly. If we receive the necessary information within two years of payment of the claim, we will adjust payments accordingly.
- In the event that the noncomplying plan reduces its benefits so you receive less than you would have received if we had paid as the secondary plan and the noncomplying plan was primary, we will advance an amount equal to the difference. In no event will we advance more than we would have paid had this plan been primary, minus any amount previously paid. In consideration of the advance, we will be subrogated to all of your rights against the noncomplying plan. See *Subrogation*, page 74.
- If the preceding rules do not determine the order of benefits and if the plans cannot agree on the order of benefits within 30 calendar days after the plans have received all information needed to pay the claim, the plans will pay the claim in equal shares and determine their relative liabilities following payment. However, we will not pay more than we would have paid had this plan been primary.

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.

Plans That Provide Benefits as Services
A secondary plan that provides benefits in the form of services may recover the reasonable cash value of the service from the primary plan, to the extent benefits for the services are covered by the primary plan and have not already been paid or provided by the primary plan.

Coordination with Medicare

Medicare is by law the secondary coverage to group health plans in a variety of situations.

The following provisions apply only if you have both Medicare and employer group health coverage and meet the specific Medicare Secondary Payer provisions for the applicable Medicare entitlement reason.

Medicare Part B Drugs
Drugs paid under Medicare Part B are covered under the medical benefits of this plan.

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

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

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

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

End-Stage Renal Disease (ESRD)
The ESRD requirements apply to group health plans of all employers, regardless of the number of employees. Under these requirements, Medicare is the secondary payer during the first 30 months of Medicare eligibility if both of the following are true:

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

If the beneficiary is already covered by Medicare due to age or disability and the beneficiary becomes eligible for Medicare ESRD coverage, Medicare generally is the secondary payer during the first 30 months of ESRD eligibility. However, if the group health plan is secondary to Medicare (based on other Medicare secondary-payer requirements) at the time the beneficiary becomes eligible for ESRD, the group health plan remains secondary to Medicare.

This is only a general summary of the laws. For complete information, contact your employer or the Social Security Administration.

10. Appeals

Right of Appeal

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

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

How to Request an Internal Appeal

You or your authorized representative, if you have designated one, may appeal an adverse benefit determination within 180 days from the date you are notified of our adverse benefit determination by submitting a written appeal. Appeal forms are available at our website, *Wellmark.com*. See *Authorized Representative*, page 71.

Medically Urgent Appeal

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

Non-Medically Urgent Appeal

To appeal an adverse benefit determination that is not medically urgent, you must make your request for a review in writing.

What to Include in Your Internal Appeal

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

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

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

Where to Send Internal Appeal

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

Review of Internal Appeal

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

opportunity to respond to that information or to provide information.

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

Medically Urgent Appeal

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

All Other Appeals

For all other appeals, you will be notified in writing of our decision. Most appeal requests will be determined within 30 days and all appeal requests will be determined within 60 days.

Second Level Appeal

You have a right to a second level internal appeal to the board of trustees.

External Review

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

- Medical necessity.
- Appropriateness of services or supplies, including health care setting, level of care, or effectiveness of treatment.
- Investigational or experimental services or supplies.
- A surprise bill.
- Concurrent review or admission to a facility. See *Notification Requirements and Care Coordination*, page 41.
- A rescission of coverage.

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

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

Have you exhausted the appeal process? Before you can request an external review, you must first exhaust the internal appeal process described earlier in this section. However, if you have not received a decision regarding the adverse benefit determination within 30 days following the date of your request for an appeal, you are considered to have exhausted the internal appeal process.

Requesting an external review. You or your authorized representative may request an external review through the Iowa Insurance Division by completing an External Review Request Form and submitting the form as described in this section. You may obtain this request form by calling the Customer Service number on your ID card, by visiting our website at *Wellmark.com*, by contacting the Iowa Insurance Division, or by visiting the Iowa Insurance Division's website at *www.iid.iowa.gov*.

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

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

Iowa Insurance Division
1963 Bell Avenue, Suite 100
Des Moines, IA 50315
Fax: 515-654-6500
E-mail:
iid.marketregulation@iid.iowa.gov

How the review works. Upon notification that an external review request has been filed, Wellmark will make a preliminary review of the request to determine whether the request may proceed to external review. Following that review, the Iowa Insurance Division will decide whether your request is eligible for an external review, and if it is, the Iowa Insurance Division will assign an independent review organization (IRO) to conduct the external review. You will be advised of the name of the IRO and will then have five business days to provide new information to the IRO. The IRO will make a decision within 45 days of the date the Iowa Insurance Division receives your request for an external review.

Need help? You may contact the Iowa Insurance Division at **877-955-1212** at any time for assistance with the external review process.

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

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

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

You or your authorized representative may submit an oral or written expedited external review request to the Iowa Insurance Division by contacting the Iowa Insurance Division at **877-955-1212**.

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

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 73, for important information about your arbitration and legal action rights after you have exhausted the appeal procedures in this section.

11. 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 73, 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.

12. 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 amendments.

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

Interpreting this Summary Plan Description

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

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.

Plan Year

The Plan Year has been designated and communicated to Wellmark by your group health plan's plan sponsor or plan administrator as the twelve month period commencing on the effective date of your group health plan's annual renewal with Wellmark.

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 your group sponsor.
- Our receipt of proper notification that an event has changed your spouse or dependent's eligibility for coverage.

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.

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

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

Release of Information

You must 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. These value added or innovative benefits are not insurance and may be changed or eliminated at any time. 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.

Value-Based Programs

Value-based programs involve local health care organizations that are held accountable for the quality and cost of care delivered to a defined population. Value-based programs can include accountable care organizations (ACOs), patient centered medical homes (PCMHs), and other programs developed by Wellmark, the Blue Cross Blue Shield Association, or other Blue Cross Blue Shield health plans ("Blue Plans"). Wellmark and Blue Plans have entered into collaborative arrangements with value-based programs under which the health care providers participating in them are eligible for financial incentives relating to quality and cost-effective care of Wellmark and/or Blue Plan members. If your physician, hospital, or other health care provider participates in the Wellmark ACO program or other value-based program, Wellmark may make available to such health care providers your health care information, including claims information, for purposes of helping support their delivery of health care services to you.

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 PPO or Participating 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.

Subrogation

For purposes of this "Subrogation" section, "third party" includes, but is not limited to, any of the following:

- The responsible person or that person's insurer;
- Uninsured motorist coverage;
- Underinsured motorist coverage;
- Personal umbrella coverage;
- Other insurance coverage including, but not limited to, homeowner's, motor vehicle, or medical payments insurance; and
- Any other payment from a source intended to compensate you for injuries resulting from an accident or alleged negligence.

Right of Subrogation

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

Right of Reimbursement

If you have an illness or injury as a result of the act of a third party or arising out of obligations you have under a contract and you or your legal representative files a claim under this group health plan, as a condition of receipt of benefits, you or your legal representative must reimburse us for all benefits paid for the illness or injury from money received from the third party or its insurer, or under the contract, to the extent of the amount paid by this group health plan on the claim.

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

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

Procedures for Subrogation and Reimbursement

You or your legal representative must do whatever we request with respect to the exercise of our subrogation and reimbursement rights, and you agree to do nothing to prejudice those rights. In addition, at the time of making a claim for benefits, you or your legal representative must inform us in writing if you have an illness or injury caused by a third party or arising out of obligations you have under a contract. You or your legal representative must provide the following information, by registered mail, as soon as reasonably practicable of such illness or injury to us as a condition to receipt of benefits:

- The name, address, and telephone number of the third party that in any way caused the illness or injury or is a party to the contract, and of the attorney representing the third party;
- The name, address and telephone number of the third party's insurer and any insurer of you;
- The name, address and telephone number of your attorney with respect to the third party's act;
- Prior to the meeting, the date, time and location of any meeting between the third party or his attorney and you, or your attorney;

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

Send this information to:

Wellmark Blue Cross and Blue Shield of Iowa
1331 Grand Avenue, Station 5W580
Des Moines, IA 50309-2901

You also agree to all of the following:

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

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

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

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

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

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

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

Workers' Compensation

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

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

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

Payment in Error

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

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.

Submitting a Complaint

If you are dissatisfied or have a complaint regarding our products or services, call the Customer Service number on your ID card. We will attempt to resolve the issue in a timely manner. You may also contact Customer Service for information on where to send a written complaint.

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.

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

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

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

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

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

Continuing Care Patient is an individual who, with respect to a provider or facility:

- is undergoing a course of treatment for a serious or complex condition from the provider or facility;
- is undergoing a course of institutional or inpatient care from the provider or facility;
- is scheduled to undergo nonelective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery;
- is pregnant and undergoing a course of treatment for the pregnancy, including postpartum care related to childbirth and delivery from the provider or facility; or
- is or was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) and is receiving treatment for such illness from such provider or facility.

Creditable Coverage. Any of the following categories of coverage:

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

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

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

Habilitative Services. Health care services that help a person keep, learn, or

improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

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

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

Medically Urgent. A situation where a longer, non-urgent response time could seriously jeopardize the life or health of the plan member seeking services or, in the opinion of a physician with knowledge of the member's medical condition, would subject the member to severe pain that cannot be managed without the services in question.

Medicare. The federal government health insurance program established under Title XVIII of the Social Security Act for people age 65 and older and for individuals of any age entitled to monthly disability benefits under Social Security or the Railroad Retirement Program. It is also for those with chronic renal disease who require hemodialysis or kidney transplant.

Member. A person covered under this group health plan.

Office. An office setting is the room or rooms in which the practitioner or staff provide patient care.

Out-of-Network Provider. A facility or practitioner that does not participate with Wellmark or any other Blue Cross or Blue Shield Plan.

Outpatient. Services received, or a person receiving services, in the outpatient department of a hospital, an ambulatory surgery center, Licensed Psychiatric or Mental Health Treatment Facility, Licensed Substance Abuse Treatment Facility, or the home.

Participating Providers. These providers participate with a Blue Cross and/or Blue Shield Plan in another state or service area, but not with a preferred provider program.

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

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

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

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

Serious and Complex Condition. A condition, with respect to a participant, beneficiary, or enrollee under a group health plan or group or individual health insurance coverage:

- in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or
- in the case of a chronic illness or condition, a condition that:
  - is life-threatening, degenerative, potentially disabling, or congenital; and
  - requires specialized medical care over a prolonged period of time.

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

Spouse. A man or woman lawfully married to a covered member.

Urgent Care Centers provide medical care without an appointment during all hours of operation to walk-in patients of all

ages who are ill or injured and require immediate care but may not require the services of a hospital emergency room.

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

X-ray and Lab Services. Tests, screenings, imagings, and evaluation procedures identified in the American Medical Association's Current Procedural Terminology (CPT) manual, Standard Edition, under *Radiology Guidelines* and *Pathology and Laboratory Guidelines*.

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

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Wellmark Language Assistance

Discrimination is against the law

Wellmark Blue Cross and Blue Shield complies with applicable state and federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

Wellmark provides:

- Free aids and services to people with disabilities so they may communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

You have the right to get this information and help in your language for free. If you need these services, call 800-524-9242.

ATENCIÓN: Si habla español, los servicios de asistencia de idiomas se encuentran disponibles gratuitamente para usted. Comuníquese al 800-524-9242 o al (TTY: 888-781-4262).

注意：如果您说普通话，我们可免费为您提供语言协助服务。请拨打 800-524-9242 或（听障专线：888-781-4262）。

CHÚ Ý: Nếu quý vị nói tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ miễn phí có sẵn cho quý vị. Xin hãy liên hệ 800-524-9242 hoặc (TTY: 888-781-4262).

NAPOMENA: Ako govorite hrvatski, dostupna Vam je besplatna podrška na Vašem jeziku. Kontaktirajte 800-524-9242 ili (tekstualni telefon za osobe oštećena sluha: 888-781-4262).

ACHTUNG: Wenn Sie deutsch sprechen, stehen Ihnen kostenlose sprachliche Assistenzdienste zur Verfügung. Rufnummer: 800-524-9242 oder (TTY: 888-781-4262).

تنبيه: إذا كنت تتحدث اللغة العربية، فإننا نوفر لك خدمات المساعدة اللغوية المجانية. اتصل بالرقم 800-524-9242 أو (خدمة الهاتف النصي: 888-781-4262).

ສ່ຽງຄວນເອົາໃຈໃສ່, ພາສາລາວ ຖ້າທ່ານເວົ້າ: ພວກເຮົາມີບໍລິການຄວາມຊ່ວຍເຫຼືອດ້ານພາສາ ໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ ຫຼື 800-524-9242 ຕິດຕໍ່ທີ. (TTY: 888-781-4262.)

주의: 한국어 를 사용하시는 경우, 무료 언어 지원 서비스를 이용하실 수 있습니다. 800-524-9242번 또는 (TTY: 888-781-4262)번으로 연락해 주십시오.

ध्यान रखें : अगर आपकी भाषा हिन्दी है, तो आपके लिए भाषा सहायता सेवाएँ, नि:शुल्क उपलब्ध हैं। 800-524-9242 पर संपर्क करें या (TTY: 888-781-4262)।

ATTENTION : si vous parlez français, des services d'assistance dans votre langue sont à votre disposition gratuitement. Appelez le 800 524 9242 (ou la ligne ATS au 888 781 4262).

Geb Acht: Wann du Deitsch schwetze duscht, kannscht du Hilf in dei eegni Schprooch koschdefrei griege. Ruf 800-524-9242 odder (TTY: 888-781-4262) uff.

โปรดทราบ: หากคุณพูด ไทย เรามีบริการช่วยเหลือด้านภาษาสำหรับคุณโดยไม่คิดค่าใช้จ่าย ติดต่อ 800-524-9242 หรือ (TTY: 888-781-4262)

PAG-UKULAN NG PANSIN: Kung Tagalog ang wikang ginagamit mo, may makukuha kang mga serbisyong tulong sa wika na walang bayad. Makipag-ugnayan sa 800-524-9242 o (TTY: 888-781-4262).

တၢ်နှးသ့ဉ်ညါ–နမ့ၢ်ကတိၤကညီကျိာ်.ကျိာ်တၢ်မၤစၢၤတၢ်ဖံးတၢ်မၤတဖဉ်.လၢတဘဉ်လာ်ဘူးလဲ.ဆိဉ်လၢနဂၢ်လီၤ.ဆဲးကျိးဆူ ၈၀၀–၅၂၄–၉၂၄၂မ့တမ့ၢ်(TTY:၈၈၈–၇၈၁–၄၂၆၂)တက့ၢ်.

ВНИМАНИЕ! Если ваш родной язык русский, вам могут быть предоставлены бесплатные переводческие услуги. Обращайтесь 800-524-9242 (телетайп: 888-781-4262).

सावधान: यदि तपाईं नेपाली बोल्नुहुन्छ भने, तपाईंका लागि नि:शुल्क रूपमा भाषा सहायता सेवाहरू उपलब्ध गराइन्छ। 800-524-9242 वा (TTY: 888-781-4262) मा सम्पर्क गर्नुहोस्।

ማሳሰቢያ: አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ እገዛ አገልግሎቶች፣ ከክፍያ ነፃ፣ ያገኛሉ። በ 800-524-9242 ወይም (በTTY: 888-781-4262) ይሙላው ያነጋግሩን።

HEETINA To a wolwa Fulfulde laabi walliinde dow wolde, naa e njobdi, ene ngoodi ngam maaɗa. Heƃir 800-524-9242 malla (TTY: 888-781-4262).

FUULEFFANNAA: Yo isin Oromiffaa, kan dubbattan taatan, tajaajiloonni gargaarsa afaanii, kaffaltii malee, isiniif ni jiru. 800-524-9242 yookin (TTY: 888-781-4262) quunnamaa.

УВАГА! Якщо ви розмовляєте українською мовою, для вас доступні безкоштовні послуги мовної підтримки. Зателефонуйте за номером 800-524-9242 або (телетайп: 888-781-4262).

Ge': Diné k'ehjí yáníłti'go níká bizaad bee áká' adoowoł, t'áá jiik'é, náhóló. Kojį' hólne' 800-524-9242 doodaii' (TTY: 888-781-4262)

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