

Benefits Certificate

House Staff Insurance



You should receive most health care services at the University of Iowa Hospitals and Clinics (UIHC) as part of a separate program through the University. No claims will be submitted to Wellmark for those services.

This certificate provides benefits only for care received as a result of illness or injury while you or your dependents are away from Iowa City for short period of time, such as for assigned rotations or approved vacations, and for instances when it is impractical to receive care at UIHC.

NOTICE

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

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Your health care coverage is called *House Staff*

Insurance. Your health care coverage provides benefits for care received as a result of illness or accidental injury incurred while you and/or your dependents are away from Iowa City, Iowa, for short periods of time, such as for assigned rotations and approved vacations, and for instances in which care at University of Iowa Hospitals and Clinics (UIHC) would be impractical.

This coverage does not apply to care obtained outside of Iowa City, Iowa, at the election of the house staff member or dependent when substantially the same care is available at UIHC there are advantages when you receive covered services from participating providers. Participating providers are providers that participate with a Blue Cross and/or Blue Shield Plan.

Using the House Staff Insurance Program

What You Should Know About Participating Providers

When you receive covered services from participating providers, all of the following statements are true:

- Participating providers agree to accept our payment arrangements, which may result in savings. See *Section 3: Your Payment Obligations*.
- We make claim payments directly to participating providers. See *Section 3: Your Payment Obligations*.

What You Should Know About Nonparticipating Providers

When you receive covered services from nonparticipating providers, you will not receive any of the advantages that our contracts with participating providers offer. You may also be missing out on savings and increased benefits you would receive if services were performed by a participating provider. When you receive covered services from nonparticipating providers, all of the following statements are true:

- We do not have contracts with nonparticipating providers and they do not agree to accept our payment arrangements:
 - For covered services received from a nonparticipating practitioner, our payment is based on the lesser of the maximum allowable fee or the amount charged. You are responsible for any difference between the amount charged and our

payment for a covered service. In the case of services received outside Iowa or South Dakota, our maximum payment for services by a nonparticipating practitioner may be the lesser of Wellmark's maximum allowable fee or the amount allowed by the Blue Cross or Blue Shield Plan in the state where the practitioner is located.

- For covered services received from a nonparticipating facility, our payment is based on the covered charge.
- We do not send claim payments to nonparticipating providers. In the case of nonparticipating hospitals, M.D.'s, and D.O.'s located in Iowa, the health plan payment is made payable to the provider, but the check is sent to you. You are responsible for forwarding the check to your provider, plus any difference between the amount charged and our payment. 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.

What You Should Know About Out-of-State Providers

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

BlueCard Program. The BlueCard Program is one of the advantages of your coverage by this Wellmark Blue Cross and Blue Shield health plan. It provides conveniences and benefits outside the Iowa service area similar to those you have within our service area when you obtain covered medical services from a participating provider. Always carry your Wellmark Blue Cross and Blue Shield of Iowa identification card (or BlueCard) and present it to your provider when you receive care.

Whenever possible, before receiving services outside of Iowa, you should ask the provider if he or she participates with the Blue Cross and/or Blue Shield Plan in that state. By confirming that the provider participates, not only will you have access to the advantages explained below, but you also will know that the provider is licensed and recognized in that state. If you need assistance locating a provider who participates with a Blue Cross and/or Blue Shield Plan in a state other than Iowa, please call us at **800-643-9724** and we will help you.

When you receive covered services from participating providers outside of Iowa, all of the following statements are true:

- 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. Any

Important Information

savings due to payment arrangements or negotiated prices will appear on your explanation of health care benefits statement as *network savings*.

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

Understanding This Certificate

It's important that you understand all parts of House Staff Insurance in order to get the most out of your coverage. The words *you* and *your* refer to the plan member. *We*, *us*, and *our* refer to Wellmark Blue Cross and Blue Shield of Iowa.

This certificate outlines the benefits and obligations of this group health plan. It is divided into these main sections:

- **Benefits**
- **Services Not Covered**
- **Your Payment Obligations**
- **Filing Claims**
- **Your Certificate**
- **Glossary**

Questions We Ask When You Receive Health Care

Even though a service may appear in *Section 1: Benefits*, before you are eligible to receive benefits, we first answer all of the following questions:

Is the Service Medically Necessary? All services, supplies, devices, and drugs must be medically necessary. Even a service, supply, device, or drug listed as otherwise covered may be excluded if it is not medically necessary in the circumstances. Unless otherwise required by law, Wellmark determines whether a service, supply, device, or drug is medically necessary, and that decision is final and conclusive. Even though a provider may recommend a service or supply, it may not be medically necessary.

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

- Provided in accordance with generally accepted standards of medical practice. Generally accepted standards of medical practice are based on:
 - credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community;
 - Physician Specialty Society recommendations and the views of physicians practicing in the relevant clinical area; and

— any other relevant factors.

- Clinically appropriate in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease.
- Not provided primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the illness, injury or disease.

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

From What Type of Provider Did You Receive Care?

Did you receive care from a participating or nonparticipating provider? **Please note:** You will receive the greatest advantages when you receive covered services from a participating provider.

Is The Service Subject to Contract Limitations? Contract limitations refer to amounts that are your liability based on your contractual obligations with us. Examples of contract limitations include all of the following:

- Amounts for services that are not medically necessary. See *Is the Service Medically Necessary?* earlier in this section. You are responsible for these amounts only if:
 - You receive the services from a nonparticipating provider; or
 - You receive the services from a participating provider in Iowa or South Dakota and:
 - The provider informs you in writing before rendering the services that we 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 we determined are not medically necessary, the participating provider is responsible for these amounts.

You are also responsible for the cost if you receive services from a provider outside of Iowa and South Dakota that we determine to be not medically necessary. This is true even if the provider does not give you any written notice before the services are rendered.

- Amounts for services that are not covered by this medical benefits plan. See *Section 2: Services Not Covered*.
- Amounts for services that have reached contract maximums.
- Any difference between the covered charge and our payment when you receive services from a nonparticipating practitioner.

Interpreting This Certificate

We will interpret the provisions of this certificate 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 certificate. If any benefit in this certificate is subject to a determination of medical necessity, unless otherwise required by law, we will make that factual determination. Our interpretations and determinations are final and conclusive.

There are certain rules you must follow in order for us to properly administer your benefits. Different rules appear in different sections of your certificate. We urge you to become familiar with the entire certificate.

Section 1: Benefits

Your House Staff Insurance medical benefits plan covers many services, which are called *benefits*. All covered services are subject to contract limitations. All covered services must be medically necessary. Even though your provider may recommend a procedure, service, or supply, the care may not always be medically necessary. See the *Important Information* section at the beginning of this certificate for information about contract limitations and medical necessity.

This section is divided into the following categories:

- Facilities and Their Services
- Practitioners and Their Services
- Other Provider Services
- Special Programs
- Limited Services
- Prior Approval
- Prior Authorization for Prescription Drugs

Facilities and Their Services

Approved Facilities

Before we approve a facility for contracting or payment purposes, it must meet certain licensing, certification, and/or accreditation standards. The following is a list of general types of facilities we recognize:

Ambulatory Surgical Facility provides surgical services on an outpatient basis.

Community Mental Health Center provides outpatient treatment for mental health conditions.

Facility for Treatment of Chemical Dependency provides treatment for chemical dependency conditions.

Hospital means a facility that provides for the diagnosis, treatment, or care of injured or sick persons. The facility must be licensed as a hospital under applicable law.

Nursing Facility provides continuous skilled nursing services as ordered and certified by your attending physician. A registered nurse (R.N.) must supervise services and supplies on a 24-hour basis. The facility must be licensed as a nursing facility under applicable law.

Approved Facility Services

The following list describes approved facility services that are covered on an inpatient and outpatient basis when billed by an approved facility, unless specifically stated otherwise: **Accidental Injury Services**—but only in an outpatient department of a facility.

Anesthetics and their Administration—but not local or topical anesthesia that is billed separately from related surgical or medical procedures.

Blood.

Blood Administration.

Chemotherapy Services for treatment of a malignancy.

Corneal Grafts.

Dietary Services—but only as an inpatient.

Dressings and Casts such as gauze, cotton, and fabric plaster.

Drugs and Biologicals. The drugs and biologicals must be approved by the Food and Drug Administration. This category includes such supplies as globulin, serum, vaccine, antitoxin, or antigen used in the prevention or treatment of disease—but not blood, blood derivatives, or blood components.

Education, Training, and Activity Therapy when received as part of an outpatient program for treatment of mental health or chemical dependency in a University Hospital or Clinic.

Emergency Care.

Hemodialysis Services when provided to you as an inpatient of a hospital or as an outpatient in a Medicare-approved dialysis center.

Inhalation Therapy.

Intravenous Injections and Solutions.

Medical and Surgical 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.

Physical Therapy.

Rooms—including general nursing care and meals.

Special Care Units including burn care units, cardiac care units, delivery rooms, intensive care units, isolation rooms, operating rooms, and recovery rooms.

Speech Therapy. You are covered for rehabilitative speech therapy treatment but only to restore speech abilities lost due to illness or injury. We recommend that you receive prior approval before receiving speech therapy. See *Prior Approval* later in this section. Also see *Speech Therapy* under *Therapy, Self-Motivation, and Other Programs* in *Section 2: Services Not Covered*.

Practitioners and Their Services

Approved Practitioners

We cover services you receive from most practitioners who are recognized by us and who meet certain licensing,

accreditation, and certification standards. The following is a list of some of the practitioners we recognize:

Advanced Registered Nurse Practitioners.

Audiologists.

Chiropractors.

Doctors of Osteopathy (D.O.).

Licensed Independent Social Workers.

Medical Doctors (M.D.).

Occupational Therapists—but only for services to treat the upper extremities, which means the arms from the shoulders to the fingers.

Optometrists.

Oral Surgeons.

Physical Therapists.

Physician Assistants.

Podiatrists.

Psychologists.

Speech Pathologists.

Approved Practitioner Services

The following list describes services we cover when received from an approved practitioner:

Accidental Injury Services received as an outpatient.

Anesthetics and their Administration—but not the administration of local or topical anesthesia that is billed separately from related surgical or medical procedures.

Assisting Surgeon Services.

Chemotherapy Services for treatment of a malignancy.

Concurrent Care is care for more than one medical condition when the conditions require the skills of different practitioners. (If more than one practitioner treats the same condition, and the condition does not require the skills of different practitioners, you are only covered for treatment from one practitioner.)

Computerized Tomography Scan (CT Scan).

Consultation Services of a medical, surgical, obstetrical, pathological, or radiological consultant when requested by your attending practitioner. The consultation must include an actual examination by the consulting practitioner, and any services ordered or performed must be documented in the patient's medical record and communicated to the requesting practitioner.

Corneal Grafts.

Dental Services are limited to the following list:

Anesthesia. Subject to any restrictions on dental coverage provided in this certificate, you are covered for general anesthesia and hospital or ambulatory surgical facility services related to the provision of dental services if the member:

- is a child under age 14 who, based on a determination by a licensed dentist and the child's treating physician, has 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

- has, based on a determination by a licensed dentist and the member's treating physician, one or more medical conditions that would create significant or undue medical risk for the member in the course of delivery of any necessary dental treatment or surgery if not rendered in a hospital or ambulatory surgical facility.

Correction of Bone Abnormalities of the jaw that are demonstrable at birth.

Correction of a Lesion (an abnormal change in the mouth due to injury or disease).

Dental Treatment for Accidental Injury must be completed within six months of the injury. Injuries associated with or resulting from the act of chewing are never covered.

Incisions of accessory sinus, mouth, salivary glands, or ducts.

Manipulation of a jaw dislocation.

Reduction of Facial Bone Fractures.

Surgical Removal of Impacted Teeth as an inpatient or outpatient of a facility only when you have a medical condition (such as hemophilia) that requires hospitalization.

Treatment of Temporomandibular Joint disorders (TMD).

Emergency Care.

Hemodialysis Services when provided to you as an inpatient of a hospital or as an outpatient in a Medicare-approved dialysis center.

Holter Monitoring.

Imaging and Laboratory Services are covered for the diagnosis and treatment of an illness or injury.

Maternity Services including prenatal and postnatal care, complications, and delivery. In accordance with federal or applicable state law, maternity services include:

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

A practitioner is not required to seek our 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.

Medical Services (other than surgical or obstetrical) provided by your practitioner while you are an inpatient or an outpatient. Home and office visits are covered unless they are for routine physical examination or screening procedures. This limitation does not apply to routine medical services described later in this section.

Musculoskeletal Treatment.

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.

Pathology Tests.

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Physical Therapy.

Radiation Therapy.

Routine Medical Services must be provided at The University of Iowa Hospitals and Clinics to be covered:

Mammograms according to the following schedule:

- For women 35-39 year of age; one base line mammogram.
- For women 40-49 year of age; one mammogram every two years.
- For women 50 years of age and older; one mammogram every year.

For this benefit, a year is 12 consecutive months. Mammograms may be more frequent if recommended by your physician.

Pap Smears.

Well-Child Care until the child reaches age seven.

Well-child care includes such services as normal newborn care, physical examinations, developmental assessments, immunizations, and laboratory services.

Stress Tests.

Surgical Services, which include operative and cutting procedures, major endoscopic procedures, and preoperative and postoperative care.

Tubal Ligation or Vasectomy—but only for the initial surgery. Benefits do not include the reversal of a vasectomy or tubal ligation.

Ultrasound.

Other Provider Services

Approved Services

Your benefits also include the following services:

Ambulance Services (professional air or ground) to the nearest adequate hospital or nursing facility to treat your illness or injury. Local air and ground ambulance means that you are transported to a hospital or nursing facility in the surrounding area where your ambulance transportation began. To determine if we will cover your ambulance transportation, we consider all of the following:

- No other method of transportation is appropriate.
- The services necessary to treat this illness or injury are not available in the hospital or nursing facility where you may be an inpatient.
- The hospital or nursing facility is the nearest one with adequate facilities to treat your medical condition.

Costs associated with a member's transportation in an ambulance to a transplant center are subject to a limitation of **\$10,000** per transplant operation.

Home Infusion Therapy including the administration of nutrients, antibiotics, and other drugs and fluids intravenously.

Home/Durable Medical Equipment including durable medical equipment items such as wheelchairs and hospital beds, which are either purchased or rented. Benefits for rental items will never total more than the purchase price.

Oxygen and Equipment needed to administer oxygen.

Prescription Drugs and Medicines. You have coverage for most prescription drugs and medicines that bear the legend, "Caution, Federal Law prohibits dispensing without a prescription," including prescription oral contraceptives. Prescription drugs purchased outside the United States are covered only if all of the following are true:

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

You also have coverage for:

- insulin, insulin syringes, and other insulin supplies.
- prescription contraceptive devices and implanted and injected contraceptives.

Please note: If you purchase a covered drug that is subject to a state sales tax, we will cover the amount of the tax.

Prosthetic Appliances used to replace a missing, natural part of the body and braces used to support or restrict movement of weakened or deformed body parts. This benefit does not include dental braces.

Special Programs

Diabetes Management

You are covered for 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. This includes up to 10 hours of outpatient diabetes self-management training provided within a 12-month period, plus follow-up training of up to one hour annually.

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.

Home Health Services

Home health services are covered when all of the following statements are true:

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

- Services are not more costly than alternative services that would be effective for diagnosis and treatment of your condition.

Home health services are subject to case management. See *Case Management* later in this section.

Before you receive home health services, you should request approval by calling **800-558-4409**. This is to ensure that a proposed treatment plan is medically necessary and a benefit of this medical benefits plan. Without requesting our approval before receiving services, we cannot confirm benefits.

Some covered services and supplies include:

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

Home Skilled Nursing. Treatment must be given by a registered nurse (R.N.) or licensed practical nurse (L.P.N.) from an agency accredited by the Joint Commission for Accreditation of Health Care Organizations (JCAHO) or a Medicare-certified agency. Home skilled nursing is intended to provide a safe transition from other levels of care when medically necessary, to provide teaching to caregivers for ongoing care, or to provide short-term treatments that can be safely administered in the home setting. Home skilled nursing will be coordinated by a case manager. The daily benefit for home skilled nursing services will not exceed the daily rate for a comparable level of care in a facility setting, and annual benefits will not exceed the total amount we would pay in one year for a comparable level of care in a facility setting. Custodial care is not included in this benefit. See *Case Management* later in this section.

Inhalation Therapy.

Medical Equipment.

Medical Social Services.

Medical Supplies.

Occupational Therapy—but only for services to treat the upper extremities, which means the arms from the shoulders to the fingers. You are not covered for occupational therapy supplies.

Oxygen and Equipment for its administration.

Parenteral and Enteral Nutrition.

Physical Therapy.

Prescription Drugs and Medicines administered in the vein or muscle.

Prosthetic Appliances and Braces.

Speech Therapy. You are covered for rehabilitative speech therapy treatment but only to restore speech abilities lost due to illness or injury, provided such treatment is coordinated through home health services. We recommend that you receive prior approval before receiving speech therapy. See *Prior Approval* later in this section. Also see *Speech Therapy* under *Therapy, Self-Motivation, and Other Programs* in *Section 2: Services Not Covered*.

Hospice Services

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

Hospice Respite Care offers rest and relief help for the family caring for a terminally ill patient. Inpatient respite care can take place in a nursing home, nursing facility, or hospital. Hospice respite care must be used in increments of not more than five days at a time. You are not covered for bereavement counseling and you are not covered for services of volunteers or clergy.

Before you receive hospice services, you should request approval by calling **800-558-4409**. This is to ensure that a proposed treatment plan is medically necessary and a benefit of this medical benefits plan. Without requesting our approval before receiving services, we cannot confirm benefits.

Case Management

Certain medical conditions may require costly, long-term care. A hospital may not be the most appropriate setting for your treatment. House Staff Insurance provides you with the opportunity to receive alternative benefits to help meet health care needs resulting from extreme illness or injury (providing that costs do not exceed inpatient facility costs). You, your physician, and the hospital can work with our case managers to identify and arrange alternative treatment plans to meet your special needs and to assist in preserving your health care benefits. Examples of conditions and treatment planning where case management might be appropriate are:

Brain or Spinal Cord Injury

Cystic Fibrosis

Degenerative Muscle Disorder

Hemophilia

High Risk Pregnancy

HIV/AIDS

Transplants

Some services are excluded or listed as standard plan limitations. However, we may waive certain exclusions or limitations for case management with the agreement of our medical director. Each case is handled on an individual basis and the benefit program is tailored to address the circumstances of each case.

Out-of-Area Transportation

Benefits include reimbursement when a University employee becomes ill away from his/her normal work location and needs emergency transportation home. To qualify for coverage, the illness/medical treatment must

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require a three-day hospital stay. **Please note:** This benefit is not available for dependents.

Limited Services

Cosmetic Surgery

Cosmetic surgery is limited to corrective surgery that has the primary purpose of restoring function lost or impaired as the result of an illness, accidental injury, or a birth defect. If the reason for surgery meets the criterion of restoring function, you may receive benefits even if there is an incidental improvement in physical appearance. See *Prior Approval* explained later in this section.

Complications of a noncovered cosmetic surgery are also not covered. See *Miscellaneous* and *Therapy, Self-Motivation, and Other Programs* in *Section 2: Services Not Covered*.

Breast Reconstruction After a Mastectomy. If you have a mastectomy and elect breast reconstruction in connection with the mastectomy, you are covered for 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; and
- prostheses and treatment of physical complications of the mastectomy, including lymphedemas.

Medical Evacuation

The House Staff Insurance Program will cover medical evacuation services if you become ill or have an injury at a location where adequate medical care cannot be provided. The medical evacuation generally will be to the nearest adequate medical facility. If you are from outside the United States, the medical evacuation may be to the nearest adequate medical facility or to your home country, or both. Medical evacuation expenses are limited to a **\$10,000** lifetime maximum per person. The lifetime benefits maximum is the maximum for these services that you receive under this certificate and prior certificates issued to The University of Iowa by Wellmark Blue Cross and Blue Shield of Iowa.

Before you receive medical evacuation services, you must request our precertification approval by calling us at **800-558-4409**. This benefit applies to the employee, spouse, domestic partner, or child covered under this medical benefits plan.

Morbid Obesity Surgery

Morbid obesity surgery is only covered if you meet eligibility criteria for age and medical condition and history. Not all procedures classified as weight reduction surgery are covered. Prior approval for weight reduction

surgery is strongly recommended. For information on how to submit a prior approval request, see *Prior Approval* later in this section, or call the Customer Service phone number listed on your ID card. For the criteria we use to determine prior approval, you may call the Customer Service number listed on your ID card or visit our Web site at www.wellmark.com.

Repatriation

The House Staff Insurance Program includes a **\$7,500** repatriation benefit in the event of death. This benefit applies to the employee, spouse, domestic partner, or child covered under this certificate and will be applied for those expenses related to returning the body to the person's place of residence in his or her home country. Covered expenses may include the costs of embalming or cremation, the coffin or urn, and transportation of the body or receptacle. This benefit does not include transportation expenses of anyone accompanying the body.

Transplants

You have coverage for transplants of the heart, heart and lung, lung, pancreas, kidney, simultaneous pancreas/kidney, small bowel, liver, and certain bone marrow/stem cell transfers from a living donor. Transplants are subject to case management. See *Case Management* earlier in this section.

Please note: Charges related to the donation of an organ are usually covered by the recipient's health benefits plan. However, if donor charges are not covered by the recipient's coverage, and you are a donor, the charges will be covered by this medical benefits plan.

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

Mental Health Conditions and Chemical Dependency (MHCD)

You have coverage for treatment of mental health conditions and chemical dependency. Mental health coverage includes diagnosis and treatment of these biologically based mental illnesses:

- Schizophrenia.
- Bipolar Disorders.
- Major Depressive Disorders.
- Schizo-Affective Disorders.
- Obsessive-Compulsive Disorders.
- Pervasive Developmental Disorders.
- Autistic Disorders.

Prior Approval

Before you receive certain services, supplies, or procedures, we recommend that you or someone acting on your behalf request prior approval. Prior approval helps determine whether a proposed treatment plan is medically necessary and a benefit of this medical benefits plan. Without prior approval for certain services, we cannot confirm that a proposed treatment plan is a benefit of this medical benefits plan. A service will be approved for a specific time period.

The most common services for which we recommend prior approval include, but are not limited to, the list below. For a complete list, or to ask about any other service, call the Customer Service phone number listed on your identification (ID) card, or visit our Web site at www.wellmark.com.

Cosmetic Surgery including, but not limited to: scar revisions, reconstruction of the nose (rhinoplasty), port wine stain surgery, surgery on the eyelids (blepharoplasty), and breast surgery.

Home/Durable Medical Equipment.

Morbid Obesity Surgery including, but not limited to, stomach surgery (gastroplasty), stomach stapling (gastric stapling), stomach bypass (gastric bypass), or surgery for the removal of fat from the belly wall (panniculectomy and abdominoplasty).

Speech Therapy.

Transplants:

Bone Marrow/Stem Cell Transfers.

Heart.

Heart and Lung.

Liver.

Lung.

Pancreas.

Simultaneous Pancreas/Kidney.

Small Bowel.

Treatment for Obstructive Sleep Apnea including, but not limited to, uvulopalatopharyngoplasty, mandibular-maxillary advancement, and oral appliances.

Your provider will request prior approval. Unless otherwise required by law, Wellmark will determine if the requested service is medically necessary and a benefit of this medical benefits plan from the written information provided by your provider.

After reviewing the request, we will notify you and your provider of the decision.

- If your request is approved, you know your medical benefits plan covers the specific services or procedures.
- If benefits are denied, you will receive written notice in which we will list the reason(s) for denial. We will mail our notice to the most current addresses we have on record for you and your provider.

Certain factors may alter or impact whether you receive approval. These factors include medical necessity, group health plan coverage and the date you receive services.

Group Health Plan Coverage. Approval is based on the medical benefits plan in effect for the patient on the date the approval is signed. If the benefits of your group health plan change for any reason, perhaps because of a new job or a new benefit plan, then the approval may not be valid. If the benefits of your group health plan change before the approved procedure is performed, we will need to check the benefits again.

Benefit Amount. Benefits for the approved service are limited to the amount described in the certificate in effect for the patient on the date services are provided.

Prior Authorization for Prescription Drugs

Covered Drugs

Certain drugs are covered by this medical benefits plan only with prior authorization. The prior authorization process allows us to verify that the drug is part of a specific treatment plan and is medically necessary. For a list of drugs subject to prior authorization, visit our Web site at www.wellmark.com or check with your pharmacist or physician.

We will respond to a request for prior authorization within 72 hours in a medically urgent situation or within 15 days in a non-urgent situation. We ordinarily respond at the time a call is received; however, calls received after 4:00 p.m. are considered the next business day.

To get prior authorization for your prescription:

- Your practitioner should call us at the number listed in the materials he or she has received from us with the authorization information. If we authorize the prescription, you will be able to fill your prescription at any pharmacy in the network that participates with our pharmacy benefits manager.
- If your practitioner does not provide us with the prior authorization information and you fill your prescription at a participating pharmacy, the pharmacist should contact us and/or the practitioner who prescribed the drug to obtain the information necessary for the prior authorization process. This process may result in some delay in filling your prescription. Encouraging your practitioner to complete the prior authorization process ahead of time can avoid delays.
- If you fill your prescription at a pharmacy that is not in the network of participating pharmacies, submit your claim to us. See *How to File* in *Section 4: Filing Claims*. If your Explanation of Health Care Benefits indicates that your prescription drug claim has been denied because you did not obtain prior authorization, follow the appeal process described under *Appealing a Denied Claim* in *Section 4: Filing Claims*.

Section 1: Benefits

Noncovered Drugs

Prior authorization also may allow a drug that is not normally covered to be covered if it is part of a specific treatment plan and medically necessary.

You or your practitioner must request prior authorization by calling or writing our customer service department with the following information:

- the reason the drug should be covered; and
- the length of time the drug should be covered.

Please note: If you do not receive prior authorization for a drug, you are responsible for paying the entire amount charged to the pharmacy.

Right of Appeal

You have the right to one full and fair review in case of an adverse decision in response to a prior authorization request. An adverse decision is one that denies or reduces benefits. We will review your request for an appeal once. You (or your authorized representative, if you have designated one) may appeal an adverse decision by calling the Customer Service number on your ID card or by writing within 180 days from the date of the notice of our decision to:

Wellmark Blue Cross and Blue Shield of Iowa
Health Management Department
636 Grand Avenue, Station 052
Des Moines, IA 50309-2565

Appeal Procedure

You may submit written comments, documents, or other information in support of your appeal. You will also be provided, upon written request and free of charge, reasonable access to and copies of all relevant records used in making the decision. The review will take into account all information regarding the adverse decision whether or not presented or available at the initial determination.

The review will be conducted by someone different from the original decision makers and without deference to the original decision. If a decision requires medical judgment, an appropriate medical expert will be consulted who was not previously involved in your case. The decision on appeal is final. Once a decision on appeal is reached, your right to appeal is exhausted. If the decision on appeal is adverse, you may request in writing the identity of the medical expert who was consulted.

Notification of Decision

In a medically urgent situation, we will notify you of our decision within 72 hours after receipt of your request for appeal. In non-urgent situations, we will notify you of our decision within 30 days after receipt of your request for appeal.

External Review

If you have exhausted our appeal process regarding a denial of benefits based on medical necessity, you or your provider may request an external review of our decision through the Iowa Commissioner of Insurance. Requests must be filed in writing at the following address, no later than 60 days following our decision:

Iowa Division of Insurance
330 Maple Street
Des Moines, IA 50319-0065

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

Your House Staff Insurance medical benefits plan does not provide benefits for certain procedures, services, or supplies that are listed in this *Services Not Covered* section. For your convenience, we divided this section with category headings. These category headings are not exclusions—they are meant only to help you find the information you are looking for. Actual exclusions are listed beneath the category headings.

Please note: Even if the service or supply is not specifically listed as an exclusion, it may not be covered under this medical benefits plan. Call The University Benefits Office if you are unsure if a specific service or supply is covered.

Mental Health and Chemical Dependency

Bereavement Counseling or Services. You are not covered for bereavement counseling, and you are not covered for services of volunteers or clergy.

Education, Training, and Activity Therapy. You are not covered if such services are not part of an outpatient program for treatment of mental health or chemical dependency in a University Hospital or Clinic.

Marriage or Family Counseling. You are not covered for marriage or family counseling or other training services.

Residential Facility Services. You are not covered for treatment of mental health conditions or chemical dependency received in a residential treatment facility.

Treatment for Certain Mental Health Conditions. You are not covered for treatment of certain mental health conditions, including the following:

Certain Disorders of Early Childhood, such as academic underachievement disorder.

Communication Disorders, such as stuttering and stammering.

Impulse Control Disorders, such as pathological gambling.

Nicotine Dependence.

Nonpervasive Developmental and Learning Disorders.

Sensitivity, Shyness, and Social Withdrawal Disorder.

Sexual Identification or Gender Disorders. You are also not covered for sex change surgery.

Fertility and Infertility

Donor Semen and Oocytes. You are not covered for the collection or purchase of donor semen (sperm) or oocytes

(eggs); the services of a surrogate parent; or the freezing of sperm, oocytes, or embryos.

Infertility Treatment. You are not covered for artificial insemination, in vitro fertilization, or any related infertility treatment or transfer procedure. If you have any of these procedures done, benefits for all types of infertility treatment (including drug induced stimulation of ovulation) will end beginning on the day you receive the noncovered service.

Infertility Treatment for Voluntary Sterilization. You are not covered for infertility treatment if the infertility is the result of voluntary sterilization.

Sterilization Reversal. You are not covered for the reversal of a vasectomy or tubal ligation.

Miscellaneous

Anesthesia that is Local or Topical. You are not covered for local or topical anesthesia when billed separately from related surgical or medical procedures.

Arch Supports. You are not covered for orthotic foot devices such as arch supports or in-shoe supports, orthopedic shoes, elastic supports, or examinations to prescribe or fit such foot devices, supports, or shoes.

Complications of a Noncovered Procedure. You are not covered for complications of a noncovered procedure. This exclusion does not apply to the treatment of complications resulting from smallpox vaccinations when payment for such treatment is not available through workers' compensation or government-sponsored programs.

Dental Care. You are not covered for dental care or orthodontic care except those services listed in *Section 1: Benefits* under *Approved Practitioner Services*.

Drugs Purchased Out of Country. You are not covered for prescription drugs purchased outside the United States failing the requirements specified under *Other Provider Services* in *Section 1: Benefits*. You also are not covered for routine visits to practitioners outside the U.S. for the sole purpose of obtaining prescription drugs.

Effective Date. You are not covered for services or supplies that you receive before the effective date of coverage under your medical benefits plan.

Elastic Stockings and Bandages. You are not covered for elastic stockings or bandages including trusses, lumbar braces, garter belts, and similar items that can be purchased without a prescription.

Genetic Testing. You are not covered for genetic testing.

Hearing Aids. You are not covered for hearing aids, fittings, or prescriptions.

Hearing Examinations. You are not covered for routine hearing examinations.

Investigational or Experimental Treatment. You are not covered for a service, supply, device, or drug that is investigational or experimental. A treatment is considered investigational or experimental when it has progressed to

Section 2: Services Not Covered

limited human application but has not achieved recognition as being proven effective in clinical medicine.

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

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

While we may rely on these criteria, the final decision remains at the discretion of our Medical Director, whose decision is not controlled by policies or decisions of other Blue Cross and Blue Shield member organizations.

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

- You receive the services from a nonparticipating provider; or
- You receive the services from a participating provider in Iowa or South Dakota and:
 - The provider informs you in writing before rendering the services that Wellmark determined the services to be investigational or experimental; and
 - The provider gives you a written estimate of the cost for such services and you agree in writing, before receiving the services, to assume the payment responsibility.

If you do not receive such a written notice, and do not agree in writing to assume the payment responsibility for services that Wellmark determined to be investigational or experimental, the participating provider is responsible for these amounts.

- You are also responsible for the cost if you receive services from a provider outside of Iowa or South Dakota that Wellmark determines to be investigational or experimental. This is true even if the provider does not give you any written notice before the services are rendered.

Maxillary and Mandibular Implants. You are not covered for maxillary or mandibular implants (osseointegration).

Motor Vehicles. This medical benefits plan does not cover the 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.

Nonmedical Services. You are not covered for telephone consultations, charges for failure to keep scheduled appointments, charges for completion of any form, or charges for medical information.

Over-the-Counter Products. You are not covered for most over-the-counter products, including nutritional dietary supplements. However, certain over-the-counter products prescribed by a physician may be covered. To determine if a particular over-the-counter product is covered, call the Customer Service number on your ID card.

Personal Convenience Items. You are not covered for items used for your personal convenience, such as:

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

Travel or Lodging Costs. You are not covered for expenses of travel or lodging.

Vision. You are not covered for routine eye examinations, eyeglasses, contact lenses, routine examinations for a fitting or prescription (including vision exercises), or surgery to correct eye refractions.

Wigs. You are not covered for wigs or artificial hair pieces.

Provider Type

Provider is an Immediate Family Member. You are not covered for services or supplies received from a provider who is within your immediate family (immediate family means yourself, a parent, child, or spouse/domestic partner).

Residential Treatment Facility. You are not covered for services or supplies you receive in a residential treatment facility.

Preventive and Routine Care

Foot Care. You are not covered for services or supplies related to routine foot care.

Immunizations. You are not covered for routine immunizations. This exclusion does not apply to well-child care described in *Section 1: Benefits* under *Routine Medical Services*.

Physical Examinations. You are not covered for routine physical examinations. This exclusion does not apply to well-child care described in *Section 1: Benefits* under *Routine Medical Services*.

Routine Services. You are not covered for routine, periodic physicals or health examinations, immunizations, or screening procedures which are performed solely for school, sports, employment, insurance, licensing, or travel.

Covered by Other Programs or Laws

Governmental Programs. You are not covered for services or supplies when you are entitled to claim benefits from governmental programs (except Medicaid).

Military Service. You are not covered for services or supplies that are required to treat an illness or injury received while you are on active status in the military service.

Payment Responsibility. You are not covered for services or supplies when someone else has the legal obligation to pay for your care, and when, in the absence of this medical benefits plan, you would not be charged.

Workers' Compensation Reimbursement. You are not covered for services or supplies that are compensated under the workers' compensation laws, including any 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 the workers' compensation laws if you had complied with such laws' requirements relating to notice of injury, timely filing of claims, and medical treatment authorizations. For treatment of complications resulting from smallpox vaccinations, see *Complications of a Noncovered Procedure* earlier in this section.

Therapy, Self-Motivation, and Other Programs

Acupuncture. You are not covered for services or supplies related to acupuncture.

Certain Inpatient Therapy. You are not covered for services or supplies provided primarily for occupational therapy as an inpatient.

Cosmetic Services or Supplies. You are not covered for cosmetic services or supplies unless they are provided primarily to restore function lost or impaired as the result of an illness, accidental injury, or a birth defect.

Custodial or Sanitaria Care or Rest Cures. You are not covered for custodial care, sanitaria care, or rest cures.

Massage Therapy. You are not covered for massage therapy.

Occupational Therapy Supplies. You are not covered for occupational therapy supplies.

Self-help or Self-cure Programs. You are not covered for self-help or self-cure programs.

Speech Therapy. You are not covered for rehabilitative speech therapy that does not restore speech abilities lost due to illness or injury or is not coordinated through home health services when the services are received through a home health agency. You are also not covered for speech therapy to treat certain developmental, learning disorders, or communication disorders, such as stuttering and stammering.

Weight Reduction Programs. You are not covered for weight reduction programs or supplies (including dietary

supplements, foods, equipment, laboratory testing, examinations, and prescription drugs), whether or not weight reduction is medically appropriate.

Transplants

Expenses for the Purchase of any Organ. You are not covered for expenses related to the purchase of any organ.

Mechanical or Non-Human Organs. You are not covered for services or supplies related to mechanical or non-human organs associated with transplants.

Transplant Services or Supplies. You are not covered for transplants other than heart, heart and lung, lung, pancreas, kidney, simultaneous pancreas/kidney, small bowel, liver, or bone marrow/stem cell transfer as stated in *Section 1: Benefits*.

Transportation of a Living Donor. You are not covered for expenses of transporting a living donor.

Section 3: Your Payment Obligations

How much you pay for covered services is affected by whether your provider is participating or nonparticipating. This section explains payment obligations of your House Staff Insurance medical benefits plan.

If you have any questions after reading this section, please call The University of Iowa Benefits Office.

This section covers:

- **Payment Vocabulary**

Payment Vocabulary

Benefit Period

A benefit period is the same as a calendar year and starts over each January 1. It continues even if you change benefits under group health plans sponsored by The University of Iowa and administered by Wellmark Blue Cross and Blue Shield of Iowa. The benefit period is important for calculating your benefit period maximums. The benefit period is also important for determining when visit, day, or dollar limits apply to certain services. When services are limited, the limit is reached from claim payment amounts under this benefits plan and prior benefits plans sponsored by The University of Iowa and administered by Wellmark Blue Cross and Blue Shield of Iowa in a benefit period.

If you are an inpatient in a covered facility on January 1, your benefit limitations and payment obligations for facility services will start over and will be based on the amounts in effect on the date you were admitted. However, your payment obligations for practitioner services will be based on the amounts in effect on the day you receive services.

Amount Charged

The amount charged is the amount a provider charges for any services and supplies, whether or not the services or supplies are covered under this medical benefits plan.

Covered Charge

The covered charge is the amount a provider bills for services and supplies that are covered under this medical benefits plan.

Maximum Allowable Fee

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

amount charged for a covered service or supply or the maximum allowable fee.

Payment Arrangements

We have contracting relationships with providers of health care services. We use different methods to determine payment arrangements, including negotiated fees. These payment arrangements usually result in savings, as described later in this section under *Payment Arrangement Savings*.

Payment Method for Services. Provider payment arrangements are calculated using industry methods, including but not limited to fee schedules, per diems, percentage of charge, per case, or negotiated fees. Some provider payment arrangements may include an amount payable to the provider based on the provider's performance. Performance-based amounts that are not distributed are not allocated to your specific group or to your specific claims and are not considered when determining any amounts you may owe. We reserve the right to change the methodology we use to calculate payment arrangements based on industry practice or business need. 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.

Payment Arrangement Savings. The savings from payment arrangements and other important amounts will appear on your Explanation of Health Care Benefits statement as follows:

- *Network Savings*, which reflects the amount you save on a claim by receiving services from a participating provider. For the majority of services, the savings reflects the actual amount saved on a claim. However, depending on many factors, the amount we pay a facility could be different from the covered charge. Regardless of the amount we pay a facility, your payment responsibility will always be based on the lesser of the covered charge or the maximum allowable fee.
- *Amount Not Covered*, which reflects the portion of provider charges not covered under this health plan and for which you are responsible. This amount may include services or supplies not covered; amounts in excess of a contract maximum, benefit period maximum, or lifetime benefits maximum; reductions for failure to follow a required recertification; and the difference between the amount charged and the maximum allowable fee for services from a nonparticipating provider. Examples of contract limitations are provided earlier in this certificate in the *Important Information* section.
- *Amount Paid by Health Plan*, which reflects our payment responsibility to a provider or to you. We

determine this amount by subtracting the following applicable amounts from the amount charged:

- network savings.
- contract limitations.

Wellmark Drug List

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

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

To determine if a drug is on the Wellmark Drug List, ask your physician, pharmacist, or visit our Web site at www.wellmark.com.

The Wellmark Drug List is subject to change.

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

Visit our Web site at www.wellmark.com or call us to determine whether your prescription qualifies.

Drug Company Rebates

Drug manufacturers offer rebates to pharmacy benefits managers. Wellmark receives a share of these rebates from its pharmacy benefits manager. Any rebates we receive will be retained by us and applied first to reduce the costs of administering the pharmacy program. The rebates will not be allocated to your specific group or to your specific claims and they will not be considered when determining your payment obligations.

Section 4: Filing Claims

You will receive most covered health care services at UIHC, for which no claims will be submitted to Wellmark Blue Cross and Blue Shield of Iowa. Services provided away from UIHC must be approved by the University Benefits Office. The claim lets us know the services you received, when you received them, and from which provider.

This section explains:

- **The Claim Filing Process**
- **Filing When You Have Other Coverage**
- **Appealing a Denied Claim**

The Claim Filing Process

When to File Your Claim

Effective April 1 2008, we must receive all claims within 365 days following the date of service of the claim. If you have any questions about the submission of a claim, please contact The University of Iowa Benefits Office.

Filing When You Have Other Coverage

Coordination of Benefits

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

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

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

- Group and nongroup insurance contracts and subscriber contracts.
- HMO contracts.
- Uninsured arrangements of group or group-type coverage.
- Group and nongroup coverage through closed panel plans.
- Group-type contracts.

- The medical care components of long-term contracts, such as skilled nursing care.
- Medicare or other governmental benefits (not including Medicaid).
- The medical benefits coverage of your auto insurance (whether issued on a fault or no-fault basis).

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

- Hospital indemnity coverage or other fixed indemnity coverage.
- Accident-only coverage.
- Specified disease or specified accident coverage.
- Limited benefit health coverage, as defined by Iowa law.
- School accident-type coverage.
- Benefits for non-medical components of long-term care policies.
- Medicare supplement policies.
- Medicaid policies.
- Coverage under other governmental plans, unless permitted by law.

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

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

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

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

- The primary plan pays or provides benefits according to its terms of coverage and without regard to the benefits under any other plan. Except as provided below, a plan that does not contain a coordination of benefits provision that is consistent with applicable

regulations is always primary unless the provisions of both plans state that the complying plan is primary.

- Coverage that is obtained by membership in a group and is designed to supplement a part of a basic package of benefits is excess to any other parts of the plan provided by the contract holder. (Examples of such supplementary coverage are major medical coverage that is superimposed over base plan hospital and surgical benefits and insurance-type coverage written in connection with a closed panel plan to provide out-of-network benefits.)
- The coverage that you have as an employee, plan member, subscriber, policyholder, or retiree pays before coverage that you have as a spouse or dependent. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent and primary to the plan covering the person as other than a dependent (e.g., a retired employee), then the order of benefits between the two plans is reversed, so that the plan covering the person as the employee, plan member, subscriber, policyholder or retiree is the secondary plan and the other plan is the primary plan.
- The coverage that you have as the result of active employment (not laid off or retired) pays before coverage that you have as a laid-off or retired employee. The same would be true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other plan does not have this rule and, as a result, the plans do not agree on the order of benefits, this rule is ignored.
- If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an employee, plan member, subscriber, policyholder or retiree is the primary plan and the COBRA or state or other federal continuation coverage is the secondary plan. If the other plan does not have this rule and, as a result, the plans do not agree on the order of benefits, this rule is ignored.
- The coverage with the earliest continuous effective date pays first if none of the rules above apply.
- If the preceding rules do not determine the order of benefits, the benefits payable will be shared equally between the plans. In addition, this plan will not pay more than it would have paid had it been the primary plan.

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

- If the child is covered by both parents who are married (and not separated) or who are living together, whether or not they have been married, then the coverage of the

parent whose birthday occurs first in a calendar year pays first. If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.

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

If none of these rules apply to your situation, we will follow the Iowa Insurance Division's Coordination of Benefits guidelines to determine this health plan payment.

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

Section 4: Filing Claims

plan will credit to its applicable deductible any amounts it would have credited to its deductible in the absence of other coverage.

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

Coordination with Medicare

By law, Medicare is the secondary coverage to group health plans in a variety of situations. The following provisions apply only if you have both Medicare and The University of Iowa's group health plan.

Working Aged. Under this provision, Medicare is the secondary payer if the beneficiary is both of the following:

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

Working Disabled. Under this provision, Medicare is the secondary payer if the beneficiary is all of the following:

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

End-Stage Renal Disease (ESRD). Under these provisions, Medicare is the secondary payer during the first 30 months of Medicare coverage if both of the following are true:

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

If the beneficiary is already covered by Medicare due to age or disability and becomes eligible for Medicare ESRD coverage, Medicare generally is the secondary payer during the first 30 months of ESRD eligibility. However, if the group health plan is secondary to Medicare (based on other Medicare secondary payer requirements) at the time the beneficiary becomes covered for ESRD, the group plan remains secondary to Medicare.

These are only a general summary of the laws, which may change from time to time. For more information, contact The University of Iowa Benefits Office or the Social Security Administration.

Appealing a Denied Claim

Appeal Procedure

In the event that we deny a claim in whole or in part, you have a right to one full and fair review. You (or your authorized representative, if you have designated one) may request that we review a denied claim. For more information on authorizing another person to represent you, see *Authorized Representative* in the *Your Certificate* section of this certificate. We will review your request for an appeal once.

Your request to review a claim must be made within 180 days from the claim denial. We will respond to your request within 60 days of receiving it. You must file your request in writing addressed to:

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

Your request must include:

- Date of your request.
- Your printed name and address (and name and address of the authorized representative if you have designated one).
- Identification number and claim number from your Explanation of Health Care Benefits.
- Date of service in question.

You may submit written comments, documents, or other information in support of your appeal. You will also be provided, upon request and free of charge, reasonable access to and copies of all relevant records used in making the decision. The review will take into account all information regarding the denied or reduced claim whether or not presented or available at the initial determination.

The review will be conducted by someone different from the original decision makers and without deference to the original decision. If a decision requires medical judgment, an appropriate medical expert will be consulted who was not previously involved in your case. The decision on appeal is final. Once a decision on appeal is reached, your right to appeal is exhausted. If the decision on appeal is adverse, you may request in writing the identity of the medical expert who was consulted.

External Review

If you have exhausted our appeal process regarding a denial of benefits based on medical necessity, you or your provider may request an external review of our decision through the Iowa Commissioner of Insurance. Requests must be filed in writing at the following address, no later than 60 days following our decision:

Iowa Division of Insurance
330 Maple Street
Des Moines, IA 50319-0065

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

Section 5: Your Certificate

Our responsibilities to you, as well as the conditions of your coverage with us, are defined in the documents that make up your contract. Your contract includes any application you submitted to us or to The University of Iowa, any agreement or group policy we have with The University of Iowa, any application completed by The University of Iowa, this benefits certificate, and any riders or amendments. All of the statements made by The University of Iowa or you in any of these materials will be treated by us as representations, not warranties. We will not use the statements to deny any claim unless we've furnished you with a copy of the statement.

This section explains:

- Coverage Eligibility
- Coverage Changes
- Coverage Termination
- Our Right to Recover Payments
- Other Information

Coverage Eligibility

Eligible Members

An eligible member is an employee who has met The University of Iowa's eligibility requirements and the employee's spouse/domestic partner or eligible dependent child(ren).

An eligible dependent child can be your natural child, a child placed with you for adoption or a legally adopted child, a child for whom you have legal guardianship, a stepchild, or a foster child. Dependent children must meet the following requirements:

- The child is not married and either under 25 years of age, and residing in the state of Iowa, or a full-time student (for a definition of *full-time student*, see the *Glossary* at the end of this certificate); or
- The child is totally and permanently disabled, either physically or mentally. If the dependent child is permanently disabled, the disability must have existed before the child was age 25 or while the child was a full-time student, and the child must have had continuous creditable coverage without a break of 63 days or more since on or before the child turned age 25 or while the child was a full-time student.

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

Medicare Eligibility

If you become eligible for Medicare for any reason, you must notify The University of Iowa Benefits Office immediately. If you are eligible for this coverage other than as a current employee or a current employee's spouse, your eligibility for Medicare may terminate your coverage under this medical benefits plan. See *Coordination with Medicare* in *Section 4: Filing Claims*. Also see *Coverage Continuation Under Federal Law—COBRA* explained later in this section.

Converting to a Medicare Supplement Plan. When you are no longer eligible for this employer-sponsored coverage and are enrolled in Medicare Parts A and B, you may be eligible to enroll in one of Wellmark Blue Cross and Blue Shield of Iowa's Senior Blue Medicare Supplement plans. For more information about these plans, please call **800-336-0505**.

Types of Coverage

There are different categories of coverage you may hold under this medical benefits plan.

- With single coverage, the plan member is the only one covered.
- With employee and spouse/domestic partner coverage, the plan member and his or her spouse/domestic partner are covered.
- With employee and child(ren) coverage, the plan member and his or her eligible, dependent child(ren) are covered.
- With family coverage, the plan member, his or her spouse/domestic partner, and each of his or her eligible, dependent children have coverage.

Qualified Medical Child Support Order (QMCSO)

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

A QMCSO specifies information such as:

- Your name and last known mailing address.

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

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

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

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

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

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

The University of Iowa may not revoke enrollment or eliminate coverage for a dependent unless The University of Iowa receives satisfactory written evidence that:

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

The University of Iowa is not required to maintain the dependent's coverage if:

- You or your spouse no longer paying any required premiums; or
- You or your spouse have terminated employment with The University of Iowa and have not elected to continue coverage.

When Coverage Begins

Your coverage under this medical benefits plan begins on your effective date. If you have just started a new job, check with The University of Iowa Benefits Office to find out your effective date.

Please note: Before you receive benefits under this medical benefits plan, you have agreed in your application (or in documents kept by us or The University of Iowa) to release any necessary information requested about you so we can process claims for benefits. You must allow any provider, facility, or their employee to give us information about a treatment or condition. If we do not receive the information requested, or if you withhold information in your application, your benefits may be denied.

If you fraudulently use your medical benefits plan or misrepresent or conceal material facts in your application, then we may terminate this medical benefits plan.

When Coverage Ends

Your eligibility for coverage will terminate on the last day of the month in which your last day of employment occurred with The University of Iowa. We stop payment for any services or supplies the day the certificate is terminated for any of the following reasons:

- You become unemployed.
- You become ineligible for coverage under this medical benefits plan.
- The University of Iowa decides to discontinue coverage or replaces this coverage.
- We decide to terminate coverage of all similar medical benefits plans by giving written notice to The University of Iowa 90 days prior to termination.

Your coverage will end if either of the following occurs:

- You use this medical benefits plan fraudulently or you fraudulently misrepresent or conceal material facts in your application, or The University of Iowa commits fraud or makes an intentional misrepresentation of a material fact under the terms of this certificate. If this happens, we will recover any claim payments we made.
- You or The University of Iowa fails to make payments to us when due.

Authority to Terminate, Amend, or Modify. The University of Iowa has the authority to terminate, amend, or modify the coverage described in this certificate at any time. Any amendment or modification will be in writing and will be as binding as this certificate. If your contract is terminated, you may not receive benefits.

Continued Coverage

There are some federal and state laws that may affect your coverage with us. These laws apply to continuing your

Section 5: Your Certificate

coverage when you are no longer eligible for group coverage.

Coverage Continuation Under Federal Law—COBRA.

The Consolidated Omnibus Budget Reconciliation Act (COBRA) entitles you and your eligible dependents to continue coverage under this medical benefits plan if coverage is lost due to certain qualifying events such as your termination from employment, a divorce, or loss of a dependent status. You and your eligible dependents will be required to pay for any continuation coverage. There are other federal or state laws similar to COBRA that may apply if COBRA does not apply. Additional information regarding continuation coverage will be provided to you by The University of Iowa.

Group Conversion Coverage

If your eligibility under this group coverage ends or if your family members become ineligible for coverage, you or your family members may be eligible for a conversion policy or a Blue Transitions policy.

If you apply for group conversion coverage within 31 days or Blue Transitions coverage within 60 days of the date your employment ends or of the event making your family member ineligible for coverage, you may be eligible for coverage under a group conversion policy or Blue Transitions policy without medical underwriting.

The benefits provided by the conversion policy or Blue Transitions policy will not be identical to the coverage provided under your group health coverage and will be subject to different premium rates. For information about available benefits, eligibility criteria, and premium rates for conversion coverage or Blue Transitions coverage, contact us. We will provide you with a copy of the conversion policy upon your request.

If you are eligible for or enrolled in Medicare, you are not eligible for group conversion coverage.

Coverage Changes

Events Changing Coverage

Certain events may require or allow you to change who is covered by this medical benefits plan. These events include:

Adding Members Due to Special Enrollment Events.

The following events allow you as well as a spouse /domestic partner or any eligible children to enroll for coverage. If The University of Iowa offers more than one health benefits plan, the event also allows you to move from one plan option to another.

Birth, Adoption, or Placement for Adoption.

Execution of The University of Iowa's Domestic Partner Affidavit.

Exhaustion of COBRA Coverage.

Marriage.

Member, Spouse, or Dependent Loses Eligibility for Creditable Coverage or his or her employer or group sponsor ceases contribution to creditable coverage.

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

Addition of a Natural Child by Court Order.

Appointment as a Legal Guardian of a child.

Care of a Foster Child (when placed in your home by an approved agency).

Dependent resumes full-time student status.

Removing Family Members Due to Special Enrollment Events. The following events require you to remove the affected family member(s) from your coverage:

Death.

Divorce, Annulment, or Legal Separation.

Medicare Eligibility (see earlier in this section under *Medicare Eligibility*).

Termination of The University of Iowa's Domestic Partner Affidavit.

In case of the following coverage removal events, the affected dependent child's coverage may be continued until the next group coverage renewal date on or after the date of the event:

Completion of Full-time Schooling of a dependent if the dependent is age 25 or older.

Dependent Child who is not a full-time student or permanently disabled reaches 25 years of age.

Marriage of a dependent child.

Notification of Change

You must notify The University of Iowa of an event that changes the coverage status of members who are covered under this medical benefits plan.

In the case of a birth, adoption, or placement for adoption, you must notify The University of Iowa within 60 days of the event.

For all other events, you must notify The University of Iowa within 31 days of the event.

Please note: If you fail to provide notification of an event that requires you to change coverage, your coverage under this medical benefits plan may terminate.

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

Authorized Certificate Changes

No agent, employee, or representative of ours is authorized to vary, add to, change, modify, waive, or alter any of the provisions of this certificate. This certificate cannot be changed except by:

- written amendment signed by an authorized officer and accepted by you or The University of Iowa.
- our receipt of proper notification that an event has changed your spouse/domestic partner or dependent's eligibility for coverage, as described under *Events Changing Coverage*. See *Types of Coverage* explained earlier in this section.

Coverage Termination

Effects of Termination

If your group health plan is terminated for fraud, misrepresentation, or the concealment of material facts:

- we will not pay for any services or supplies provided after the date the group health plan is terminated.
- we will retain legal rights. This includes the right to initiate a civil action based on fraud, concealment, or misrepresentation.
- we may, at our option, declare the certificate void.

If your group health plan is terminated for reasons other than fraud, concealment, or misrepresentation of material facts, we will stop benefits the day your group health plan is terminated.

An exception to this applies only when you receive benefits as an inpatient of a hospital or a resident of a nursing facility on the date the group health plan terminates. However, benefits for inpatient services are limited to the least amount of the following:

- A period equal to your remaining days of coverage under the group health plan.
- A period ending on the date you are discharged from the hospital or nursing facility.
- A period not more than 60 days from the date the group health plan is terminated.

Our Right to Recover Payments

Subrogation

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

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

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

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

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

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

- The name, address, and telephone number of the third party that in any way caused the injury, and of the attorney representing the third party;
- The name, address and telephone number of the third party's insurer and any insurer of you;
- The name, address and telephone number of your attorney with respect to the third party's act;
- Prior to the meeting, the date, time and location of any meeting between the third party or his attorney and you, or your attorney;
- All terms of any settlement offer made by the third party or his insurer or your insurer;
- All information discovered by you or your attorney concerning the insurance coverage of the third party;

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- The amount and location of any money that is recovered by you from the third party or his insurer or your insurer, and the date that the money was received;
- Prior to settlement, all information related to any oral or written settlement agreement between you and the third party or his insurer or your insurer;
- All information regarding any legal action that has been brought on your behalf against the third party or his insurer; and
- All other information requested by us.

Send this information to:

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

You also agree to all of the following:

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

It is further agreed that in the event that you fail to take the necessary legal action to recover from the responsible party, we shall have the option to do so and may proceed in its name or your name against the responsible party and shall

be entitled to the recovery of the amount of benefits paid under this group health plan and shall be entitled to recover its expenses, including reasonable attorney fees and costs, incurred for such recovery.

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

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

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

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

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

Workers’ Compensation

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

Furthermore, we are entitled to reimbursement from you to the extent of benefits paid under this medical benefits plan out of any proceeds you receive in settlement of any workers’ compensation claim regardless of whether the settlement is a compromise or disputed settlement and regardless of any characterization of the settlement proceeds by the parties to the settlement.

We utilize industry standard methods to identify claims which may be the result of work related injuries. This may result in some initial claims that are the result of work related injuries being paid. We reserve the right to seek reimbursement of any such claims or to waive the right to seek reimbursement on any specific claim, in our sole discretion.

Payment in Error

If for any reason we make payment under this medical benefits plan in error, we may recover the amount we paid.

Other Information

Authorized Representative

You may authorize another person to represent you and with whom you want us to communicate regarding specific claims or an appeal. This authorization must be in writing, signed by you, and include all the information required in our Authorized Representative Form. This form is available at www.wellmark.com or by calling Customer Service. 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 can revoke the authorized representative at any time, and you can authorize only one person as your representative at a time.

Notice

If a specific address has not been provided elsewhere in this certificate, you may send any notice to our home office:

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

Any notice from us to you is acceptable when sent to your address as it appears on our records or the address of The University of Iowa.

Confidentiality and Release of Information

The University of Iowa is committed to protecting the privacy of your health information. It will request, use, or disclose your health information only as permitted or required by law. For example, The University of Iowa 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 claims from physicians, hospitals, and other providers for covered services, to determine your eligibility for benefits, to coordinate benefits, to determine medical necessity, to obtain payment from The University of Iowa, to issue explanations of benefits to the person

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

Member Health Support Services

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

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

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

Value Added or Innovative Benefits

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

Section 5: Your Certificate

Health Insurance Portability and Accountability Act of 1996

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

Purpose of Disclosure to Group Sponsor. Your group health plan, any business associate servicing your group health plan, or Wellmark will disclose protected health information to your group sponsor only to permit the group sponsor to perform plan administration of the group health plan consistent with the requirements of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (45 C.F.R. Parts 160-64). Any disclosure to and use by your group sponsor of protected health information will be subject to and consistent with the provisions identified under *Restrictions on Group Sponsor's Use and Disclosure of Protected Health Information* and *Adequate Separation Between the Group Sponsor and the Group Health Plan*, later in this section.

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

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

Restrictions on Group Sponsor's Use and Disclosure of Protected Health Information. Your group sponsor will not use or further disclose protected health information, except as permitted or required by this provision, or as required by law.

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

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

Your group sponsor will report to the group health plan, any use or disclosure of protected health information that is inconsistent with the uses and disclosures stated in this provision promptly upon learning of such inconsistent use or disclosure.

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

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

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

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

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

Your group sponsor will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic protected health information.

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

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

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

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

Individuals granted access to protected health information of affiliation with the group sponsor, for any use or disclosure of protected health information in violation of or noncompliance with this provision. The group sponsor will promptly report such violation or noncompliance to the group health plan, and will cooperate with the group health plan to correct the violation or noncompliance, to impose appropriate disciplinary action or sanctions on each employee causing the violation or noncompliance, and to mitigate any negative effect the violation or noncompliance may have on the member, the privacy of whose protected health information may have been compromised by the violation or noncompliance.

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

Certificate of Creditable Coverage

We will provide certification of your coverage with us in the following instances:

- This coverage terminates.
- You become eligible for COBRA coverage or coverage continuation under Iowa law.
- You exhaust your COBRA coverage.
- You request certification of your coverage by writing us at the above address or calling **800-355-2031** within 24 months after your coverage terminates.

Nonassignment

Benefits for covered services in this medical benefits plan are for your personal benefit and cannot be transferred or assigned to anyone else without our consent. Any attempt to assign this certificate or rights to payment without our consent will be void.

Governing Law

To the extent not superseded by the laws of the United States, this medical benefits 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 medical benefits 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 and the external review process described in the *Filing Claims* section of this certificate.

You shall not bring any legal or equitable action against us because of a claim under this medical benefits plan, or because of the alleged breach of this medical benefits plan, more than two years after the end of the calendar year in which the services or supplies were provided.

Member Contribution

The University of Iowa determines the amount you may be required to pay for your group health plan. For additional information about contributions to your group health plan, please contact The University of Iowa Benefits Office.

Information if You or a Member of Your Family is Enrolled in Medicaid

Assignment of Rights. This 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 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 we have a legal obligation to provide benefits for those services, then we will make payment of those benefits in accordance with any state law under which a state acquires the right to such payments.

Glossary

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

Admission is the formal acceptance of a patient into a hospital or other health care institution for a health condition.

Advanced Registered Nurse Practitioner (ARNP) means 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.

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

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

Approved Services are those services and supplies covered under this medical benefits plan.

Assisting Surgeon means a surgeon who is a medical doctor or a doctor of osteopathy.

Benefit Period is the same as a calendar year and begins on the day your coverage goes into effect.

Benefits means those medically necessary services and supplies that qualify for payment under this medical benefits plan.

BlueCard Program is the Blue Cross and Blue Shield Association program that permits members of any Blue Cross and/or Blue Shield Plan to have access to the advantages of participating providers throughout the United States.

Braces include rigid and semi-rigid appliances and devices commonly used to support a weak or deformed body part or to restrict or eliminate motion in a diseased or injured part of the body. Braces do not include elastic stockings, elastic bandages, garter belts, arch supports, orthodontic devices, or other similar items.

Case Management is a provision which addresses the specialized care needs of patients with severe illnesses or injuries. Arrangements may be made to waive standard plan limitations to provide a more appropriate and comfortable setting for continued treatment.

Chemical Dependency means a condition with physical or psychological symptoms produced by the habitual use of certain drugs as described in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition-Revised*, (DSM-IV-R), or subsequent revisions to DSM-IV-R.

Community Mental Health Center provides outpatient treatment of mental health conditions.

Complications of Pregnancy means a cesarean section that was not planned, an ectopic pregnancy that is terminated, or a spontaneous termination of pregnancy that occurs during a period of gestation in which a viable birth is not possible. Complications of pregnancy also include conditions requiring inpatient hospital admission (when pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy.

Contraceptive Device means one of the following prescription devices to prevent conception, which has been approved by the U.S. Food and Drug Administration: diaphragm, subcutaneous implant, intrauterine device, or cervical cap.

Contract includes any application you submitted to us or The University of Iowa, any agreement or group policy we have with The University of Iowa, any application completed by The University of Iowa, this benefits certificate, and any riders or amendments.

Contract Limitations are amounts that are your liability based on your contractual obligations with us. Examples of contract limitations include services that are not covered, services that are not medically necessary, and services that have reached contract maximums.

Contract Maximums are the maximum benefit amounts members are eligible to receive per service, benefit period, or lifetime for covered services.

Coordination of Benefits (COB) applies when you are covered by more than one group contract or insurance policy providing benefits for like services. COB is a method of limiting benefits to no more than 100 percent of either our payment arrangement amount or the other carrier's payment arrangement amount.

Covered Services are those medically necessary procedures, services, or supplies listed in this certificate in *Section 1: Benefits*.

Creditable Coverage means any of the following types of coverage that you, the member, had without a break in coverage of 63 days or more:

- A group health plan (including government and church plans).

- Health insurance coverage (including group, individual, and short-term limited duration coverage).
- Part A or B of Title XVIII of the Social Security Act (Medicare).
- Title XIX of the Social Security Act (Medicaid).
- 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.
- A health plan offered under Chapter 89 of Title 5, United States Code (Federal Employee Health Benefit Plan).
- 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 benefit plan under Section 5(e) of the Peace Corps Act.
- An organized delivery system licensed by the director of public health.

Custodial Care helps you meet 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. Custodial care is not a benefit under this medical benefits plan.

Dependent Child means your natural child, a child placed with you for adoption or a legally adopted child, a child for whom you have legal guardianship, a stepchild, or a foster child. To be eligible for coverage, the child must be unmarried and either under 25 years of age, a full-time student, or totally and permanently disabled, either physically or mentally. If the dependent child is permanently disabled, the disability must have existed before the child was age 25 or while the child was a full-time student, and the child must have had continuous creditable coverage without a break of 63 days or more since on or before the child turned age 25 or while the child was a full-time student. A dependent child who has been placed in your home for the purpose of adoption or whom you have adopted shall be eligible for coverage as of the date of placement for adoption or the date of actual adoption, whichever occurs first.

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

Domestic Partner means your partner who may qualify for coverage under this certificate. To qualify as a domestic partner, you and your domestic partner must file an “Affidavit of Domestic Partnership” with The University of Iowa Benefits Office.

Effective Date is the date upon which this medical benefits plan goes into effect.

Emergency means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of health and medicine, could reasonably expect absence of immediate medical attention to result in one of the following:

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

Emergency Admission is one that must take place immediately or serious disability or death may result.

Employee and Child(ren) Coverage means coverage for the plan member and his or her eligible dependent child(ren).

Employee and Spouse/Domestic Partner Coverage means coverage for the plan member and his or her spouse/domestic partner.

Enteral means an agent that is delivered through the digestive tract and absorbed naturally.

Explanation of Health Care Benefits is a statement you receive in the mail from us that outlines how we applied benefits to a submitted claim.

Facility is a licensed, certified, and/or accredited facility that provides inpatient and outpatient services. Examples of facilities include hospitals, nursing facilities, and ambulatory surgical facilities.

Facility to Treat Chemical Dependency is a licensed freestanding facility that is approved by us to provide treatment for chemical dependency conditions.

Family Coverage means coverage for the plan member and his or her eligible family members.

Family Member means any member of a plan member’s family (including the plan member) covered under this medical benefits plan.

Full-time Student is a dependent claiming status as a full-time student. The dependent must be enrolled in an

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accredited institution of higher learning, such as a college, university, nursing school, or trade school, and must be considered full-time as defined by the institution in which the dependent is enrolled. Full-time student status continues during:

- regularly scheduled school vacation periods; and
- absence from class (in which enrolled) for up to four months due to a physical or mental disability. The disability must be substantiated by a written statement from a physician.

Group is made up of those plan members who share a common relationship such as employment or membership.

Home Health Agency (HHA) is a Medicare-approved or Joint Commission for Accreditation of Health Care Organizations (JCAHO) approved agency or organization that provides skilled nursing care in your home.

Home Infusion Therapy means treatment provided in the home involving the administration of nutrients, antibiotics, and other drugs and fluids intravenously.

Home Skilled Nursing means nursing services provided in your home by an approved registered nurse (R.N.) or a licensed practical nurse (L.P.N.).

Hospice Program provides care in a comfortable setting (usually the home) for patients who are terminally ill and have a life expectancy of six months or less. Services include home health care plus respite services.

Hospice Respite Care is rest and relief help for the family caring for a terminally ill patient.

Hospital means an institution that provides for the diagnosis, treatment, or care of injured or sick persons. The facility must be licensed as a hospital under applicable law.

Identification Card/BlueCard is the card issued to you by us. The information on the card, especially the identification number, is required to process your claims correctly and answer questions you may have. You should carry your identification card with you at all times and present it to your provider at the time you receive care, even when you receive services in a state other than Iowa .

Illness or Injury means any bodily disorder, bodily injury, disease or mental health condition and includes pregnancy and complications of pregnancy.

Imaging and Laboratory Services are those 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*.

Immediate Family Member means your child, spouse/domestic partner, or parent.

Immunization is an injection with a specific antigen to promote antibody formation to make you immune to a disease or less susceptible to a contagious disease.

Inpatient Admission is a stay in an inpatient facility (usually involving overnight care).

Investigational or Experimental Treatment is a service, supply, device, or drug, that has progressed to limited human application but has not achieved recognition as being proven effective in clinical medicine.

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

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

These criteria are considered by the Blue Cross and Blue Shield Association's Medical Advisory Panel in publishing a Reference Manual for consideration by all Blue Cross and Blue Shield member organizations. While we may rely on these criteria, the final decision remains at the discretion of our Medical Director. (See *Section 2: Services Not Covered*.)

Late Enrollee means a member who declines coverage when he or she is initially eligible to enroll or at an annual group enrollment period and then later enrolls for coverage at an annual group enrollment period. A member will be considered a special enrollee upon the occurrence of a special enrollment event even if the member would otherwise be considered a late enrollee.

Maximum Allowable Fee is the amount we establish, using various methodologies, for covered services and supplies.

Mechanical Organ is an organ that is implanted in the body and replaces the natural organ.

Medicaid is a form of public assistance sponsored jointly by the federal and state governments providing medical assistance for eligible persons whose income falls below a certain level. This program is administered in Iowa by the Iowa Department of Human Services pursuant to Title XIX of the federal Social Security Act.

Medical Child Support Order (MCSO) means any judgment, decree, or order (including approval of a settlement agreement) issued by a court of competent jurisdiction that:

- provides for child support with respect to a plan member's child or a child of the plan member's spouse or provides for health benefits coverage to such a child, is made pursuant to a State domestic relations law, and relates to benefits under the health benefit plan of the plan member; or
- enforces a law relating to medical child support described in Iowa Code Chapter 252E (2001) or Section 1908 of the Social Security Act with respect to a group plan.

Medically Necessary means a covered service, supply, device, or drug that we consider eligible for benefits under this medical benefits plan. All covered services, supplies, devices, and drugs must be medically necessary. Even a service, supply, device, or drug listed as otherwise covered may be excluded if it is not medically necessary in the circumstances. Unless otherwise required by law, Wellmark determines whether a service, supply, device, or drug is medically necessary, and that decision is final and conclusive. Even though a provider may recommend a service or supply, it may not be medically necessary.

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

- Provided in accordance with generally accepted standards of medical practice. Generally accepted standards of medical practice are based on:
 - credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community;
 - Physician Specialty Society recommendations and the views of physicians practicing in the relevant clinical area; and
 - any other relevant factors.
- Clinically appropriate in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease.
- Not provided primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the illness, injury or disease.

An alternative service, supply, device, or drug may meet the criteria of medical necessity for a specific condition. If alternatives are substantially equal in clinical effectiveness

and use similar therapeutic agents or regimens, we reserve the right to approve the least costly alternative.

Medically Urgent Situation is one where a longer, non-urgent response time to a pre-service notification could seriously jeopardize the life or health of the benefit 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 (Title XVIII) is the federal government's 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 the Social Security or Railroad Retirement Program. It is also for those with chronic renal disease who require hemodialysis or kidney transplant.

Member means any person who is covered under this medical benefits plan.

Mental Health Condition means a psychiatric, psychological, or emotional condition that satisfies all of the following criteria. The disorder is:

- not a chemical dependency condition (see the definition of *chemical dependency* earlier in this *Glossary*); and
- classified as a mental health condition in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition-Revised* (DSM-IV-R) or subsequent revisions to DSM-IV-R; and
- listed only as a mental health condition in the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) or subsequent revisions to ICD-9-CM and not dually listed elsewhere in the ICD-9-CM.

See *Section 2: Services Not Covered* for mental health conditions for which treatment is not covered under this medical benefits plan.

Newborn Care means all physician services provided to a baby during the mother's hospitalization.

Nonparticipating Facility does not participate with a Blue Cross and/or Blue Shield Plan.

Nonparticipating Practitioner does not participate with a Blue Cross and/or Blue Shield Plan.

Nursing Facility provides continuous skilled nursing services as ordered and certified by your attending physician. A registered nurse (R.N.) must supervise services and supplies on a 24-hour basis. The facility must be licensed as a nursing facility under applicable law.

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Other Providers means providers other than facilities and practitioners. Examples include hospice agencies, ambulance services, retail pharmacies, home medical equipment suppliers, and independent labs.

Our means Wellmark Blue Cross and Blue Shield of Iowa.

Outpatient means care received in a practitioner's office, the home, the outpatient department of a hospital, or ambulatory surgery center.

Parenteral means an agent that is administered to the body through some way other than the digestive tract. This includes injections given subcutaneously, intramuscularly, or intravenously.

Participating Facility does participate with Wellmark Blue Cross and Blue Shield of Iowa or a Blue Cross and/or Blue Shield participating Plan in another state.

Participating Practitioner does participate with Wellmark Blue Cross and Blue Shield of Iowa or a Blue Cross and/or Blue Shield participating Plan in another state.

Physician means a medical doctor (M.D.) or a doctor of osteopathy (D.O).

Placement for Adoption means you assume a legal obligation to provide full or partial support of a child you intend to adopt.

Plan Member means you, the person who signed for this certificate.

Postoperative Care is care given following a surgical operation.

Postpartum is the period of time following childbirth.

Practitioner means any individual recognized by us, licensed, and/or accredited to provide covered services. Examples include doctors of medicine, doctors of osteopathy, podiatrists, chiropractors, and physical therapists.

Prior Approval is a notification program for certain elective medical procedures. Our prior approval helps ensure that you will receive full benefits for certain procedures, such as cosmetic surgery.

Prosthetic Appliances are devices used as artificial substitutes to replace a missing natural part of the body and other devices to improve, aid, or increase the performance of a natural function. Prosthetic appliances do not include devices such as eyeglasses, air conduction hearing aids, orthopedic shoes, arch supports, orthotic devices, trusses, or examinations for their prescription or fitting.

Provider means a practitioner or facility.

Psychologist means a provider who has a doctorate degree in psychology with two years' clinical experience and who meets the standards of a national register.

Qualified Medical Child Support Order (QMCSO). A Qualified Medical Child Support Order is a Medical Child Support Order that creates or recognizes a specified person's right to enroll in the health benefits plan for which the plan member or his/her dependents are eligible. A QMCSO includes the following information:

- The name and last known mailing address (if any) of the plan member and the name and mailing address of each person specified in the order as entitled to enroll in the group health plan;
- A reasonable description of the type of coverage to be provided or the manner in which the type of coverage is to be determined;
- The period to which the order applies.

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

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

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

Service Limitations are dollar or time limitations applied to certain services.

Single Coverage means coverage for the plan member only.

Spouse means your husband or wife as the result of a marriage that is legally recognized in Iowa.

Subrogation means our rights when you or your family members receive benefits of this medical benefits plan required as the result of illness or injury and you have a lawful claim against another party or parties for compensation, damages, or other payment.

Termination Date is the date your coverage ends under this medical benefits plan.

Us means Wellmark Blue Cross and Blue Shield of Iowa.

We means Wellmark Blue Cross and Blue Shield of Iowa.

Well-Child Care means care given to a child until he or she reaches age seven. Services include age-appropriate pediatric preventive services from birth until the child reaches age seven, as defined by current recommendations for Preventive Pediatric Health Care of the American Academy of Pediatrics. Pediatric preventive services shall include, at minimum, a history and complete physical examination as well as developmental assessment, anticipatory guidance, immunizations, and laboratory services including, but not limited to, screening for lead exposure as well as blood levels.

Wellmark Drug List contains drugs physicians recognize as being medically effective for a wide range of health conditions.

You and Your means you and your family members eligible for coverage under this medical benefits plan.

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