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C O V E R A G E M A N U A L

BlueDental PPOSM

NOTICE

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

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About This Coverage Manual

Contract

This coverage manual describes your rights and responsibilities under your group health plan. For purposes of this dental coverage manual, the term group health plan represents your dental benefits plan. You and your covered dependents have the right to request a copy of this coverage manual, at no cost to you, by contacting your employer or group sponsor.

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

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

Charts

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

Complete Information

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

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

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

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

Read Thoroughly

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

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

Questions

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

1. What You Pay

This section is intended to provide you with an overview of your payment obligations under this group health plan. This section is not intended to be and does not constitute a complete description of your payment obligations. To understand your complete payment obligations you must become familiar with this entire coverage manual, especially the *Factors Affecting What You Pay* and *Choosing a Provider* sections.

Provider Types

This dental program gives you the flexibility to go to almost any provider you choose. However, which provider type you choose will affect what you pay.

In-Network Dental Providers:

PPO Dental Providers. Dental providers who participate with Blue Dental PPO and dental providers outside the Blue Dental PPO service area who participate in a PPO network with entities whom Wellmark has agreements with are called PPO dental providers. You typically pay the least for services received from these providers.

Participating Dental Providers. Dental providers who participate with Wellmark or with entities whom Wellmark has agreements with, but not with a PPO network. You typically pay more for services from these providers than for services from PPO dental providers.

Out-of-Network Dental Providers:

Out-of-Network Dental Providers. Dental providers who do not participate with entities whom Wellmark has agreements with are called Out-of-Network dental providers. You typically pay the most for services from these providers.

Payment Summary

This chart summarizes your payment responsibilities. It is only intended to provide you with an overview of your payment obligations. It is important that you read this entire section and not just rely on this chart for your payment obligations.

Category	Deductible		Coinsurance		Benefit Year Maximum††		Lifetime Maximum
	PPO	Non-PPO*	PPO	Non-PPO*	PPO	Non-PPO*	
Provider Type							
All Services	\$15 per person \$45 per family**	\$25 per person \$75 per family**			\$1,250	\$1,250	
Diagnostic and Preventive Services							
Diagnostic and Preventive Services	waived	waived	0%	0%			
Basic Services							
Basic Restorative Services (cavity repair)			10%	20%			
Oral Surgery			10%	20%			

Endodontics (root canals and pulp treatments)	20%	20%		
Periodontics (gum and bone disease)	20%	20%		
Posterior Composites	10%	20%		
Major Services				
Major Restorative Services (crowns)	50%	50%		
Prosthodontics (dentures and bridges)	50%	50%		
Repairs and Adjustments	50%	50%		
Orthodontics				
Orthodontics (Braces)	50%	50%	waived	\$1,500

*Participating and Out-of-Network dental providers are non-PPO. See *Choosing a Provider*, page 23.

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

‡Benefits for covered services will not exceed the PPO Benefit Year Maximum amount.

†Charges for covered orthodontics do not apply to the benefit year maximum.

Payment Details

Deductible

Deductible is the fixed dollar amount you pay for covered services in a benefit year before Blue Dental PPO benefits become available.

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

Deductible amounts you pay for PPO or Participating and Out-of-Network dental provider services apply toward meeting both the PPO and Participating/Out-of-Network dental deductibles. The maximum deductible amount you pay is the Participating/Out-of-Network dental deductible.

Once you meet the deductible, then coinsurance applies.

Coinsurance

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

Benefit Year Maximum

This is the maximum payment amount each member is eligible to receive for certain covered services in a benefit year.

The benefit year maximum is reached from claims settled under this benefits plan during a benefit year.

Charges for covered orthodontics do not apply to the benefit year maximum.

Benefit Year Carryover

If, at the end of the benefit year, you have unused benefit dollars, additional dollars are added to the next benefit year provided all of the following requirements are met:

- You are enrolled in this dental plan for an entire benefit year.
- At least one claim is filed for a preventive service you received within the benefit year.
- The total amount of claims applied to the benefit year maximum is less than \$625.

Carryover amounts will be placed in a carryover account. For each benefit year

that you meet the requirements listed previously, up to \$625 may be carried over until your account reaches \$1,250. Once this amount is reached, no more unused dollars will accrue until your account balance falls below \$1,250.

Please note:

- Benefit year carryover amounts can only be applied to covered benefits.
- Orthodontic lifetime maximum amounts are not applied to your carryover account.
- Carryover amounts cannot be used to increase your lifetime maximum.

If your coverage ends for any reason, the balance in your carryover account will be reduced to zero the day your benefits end under this dental plan.

Lifetime Maximum

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

2. At a Glance - Covered and Not Covered

Your coverage provides benefits for many services and supplies. There are also services for which this coverage does not provide benefits. The following chart is provided for your convenience as a quick reference only. This chart is not intended to be and does not constitute a complete description of all coverage details and factors that determine whether a service is covered or not. All covered services are subject to the contract terms and conditions contained throughout this coverage manual. Many of these terms and conditions are contained in *Details – Covered and Not Covered*, page 11. To fully understand which services are covered and which are not, you must become familiar with this entire coverage manual. Please call us if you are unsure whether a particular service is covered or not.

The headings in this chart provide the following information:

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

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

Not Covered. The listed category is generally not covered.

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

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

Category	Covered	Not Covered	See Page	Benefits Maximums
Diagnostic and Preventive Services (Preventive Check-Ups and Problem-Focused Evaluations)			11	
Cleaning (Prophylaxis)	●		11	Twice per benefit year. Regular dental cleanings (prophylaxis) reduce the number of periodontal maintenance treatments that are covered.
Fluoride Applications (Topical)	●		11	For eligible children under age 19 once per benefit year.
Oral Evaluations (Preventive Check-Ups and Problem-Focused Evaluations)	●		11	Twice per benefit year.

Category	Covered	Not Covered	See Page	Benefits Maximums
Periodontal Maintenance Therapy	●		11	Periodontal maintenance benefits are available twice per benefit year. Each periodontal maintenance treatment reduces the number of regular dental cleanings (prophylaxis) that are covered.
Sealant Applications	●		11	For eligible children under age 15. Once every two years per permanent first and second molars.
Space Maintainers	●		12	For eligible children under age 15. Once every two years.
X-rays			12	
Bitewing	●		12	Twice per benefit year.
Full-Mouth (Panoramic)	●		12	Once every three years.
Occlusal, Extraoral, and Periapical	●		12	
Basic Restorative Services (cavity repair)			12	
Anesthesia			12	
General and Intravenous Sedation	●		12	
Nitrous Oxide	●		12	
Anesthesia billed separately from the related procedure		⊖	12	
Cavity Repair	●		12	
Emergency Treatment (Palliative)	●		13	
Occlusal Adjustment			13	
Limited	●		13	
Complete		⊖	13	
Posterior Composites	●		13	Benefits are limited to the amount paid for a silver (amalgam) filling. You are responsible for any difference in cost between the composite filling and a silver filling to restore a back tooth.
Oral Surgery			13	
Basic Extractions	●		13	
Complex Extractions	●		13	
Complex Surgical Procedures	●		13	
Brush Biopsy	●		13	

Category	Covered	Not Covered	See Page	Benefits Maximums
Endodontics (root canals and pulp treatments)			13	
Apicoectomy/Periradicular Surgery	●		13	Once every two years per tooth.
Pulp Caps			14	
Direct	●		14	Once every two years per tooth.
Indirect		⊖	14	
Pulpotomy	●		14	Once every two years per tooth.
Retrograde Fillings	●		14	Once every two years per tooth.
Root Canals	●		14	Once every two years per tooth.
Periodontics (gum and bone disease)			14	
Non-Surgical Procedures (Root Planing and Scaling)	●		14	Non-surgical periodontal procedures once every two years.
Complex Surgical Procedures	●		14	Complex surgical periodontal procedures once every two years for each quadrant.
Major Restorative Services (crowns)			15	
Crowns	●		15	Once every five years.
Inlays	●		15	Once every five years. Benefits are limited to the amount paid for a silver (amalgam) filling. You are responsible for any difference in cost between a gold, porcelain, or composite filling and a silver filling. If a filling was performed on the same tooth within the previous 12 months, the benefit for the inlay will be reduced by the amount of the benefit paid for the filling. Recementing is a benefit six months after initial placement of the permanent inlay.
Onlays	●		15	Once every five years.
Posts and Cores	●		15	Once every five years.
Prosthodontics (dentures and bridges)			16	

Category	Covered	Not Covered	See Page	Benefits Maximums
Bridges	●		16	Once every five years.
Dentures and Partial	●		16	Once every five years.
Implants	●		17	Once every five years per missing tooth.
Repairs and Adjustments	●		17	
Orthodontics (Braces)			17	
Adults	●		17	Lifetime maximum of \$1,500 per person.
Children	●		17	For eligible children who are at least age eight. Lifetime maximum of \$1,500 per person.
Repair or Replacement of Orthodontic Appliances		⊖	17	

3. Details - Covered and Not Covered

All covered services or supplies listed in this section are subject to the general contract provisions and limitations described in this coverage manual. Also see the section *General Conditions of Coverage, Exclusions, and Limitations*, page 21. If a service or supply is not specifically listed, do not assume it is covered.

Diagnostic and Preventive Services

Cleaning (Prophylaxis)

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

Benefits Maximum:

- Twice per benefit year. Regular dental cleanings (prophylaxis) reduce the number of periodontal maintenance treatments that are covered.

Not Covered:

- Oral hygiene instructions, including guidance regarding home care. Some examples of oral hygiene instructions include instructions or guidance on tooth brushing technique, flossing, and/or use of special oral hygiene aids.

See Also:

Additional Condition-Specific Dental Benefits later in this section.

Fluoride Applications (Topical)

Covered. Topical application of fluoride gel to help prevent tooth decay.

Benefits Maximum:

- For eligible children under age 19 once per benefit year.

See Also:

Additional Condition-Specific Dental Benefits later in this section.

Oral Evaluations

Covered: Preventive check-ups and problem-focused evaluations (i.e., dental

examinations related to a particular injury or disease).

Benefits Maximum:

- Twice per benefit year.

See Also:

Additional Condition-Specific Dental Benefits later in this section.

Periodontal Maintenance Therapy

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

Benefits Maximum:

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

See Also:

Additional Condition-Specific Dental Benefits later in this section.

Sealant Applications or Preventive Resin Restorations

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

Benefits Maximum:

- For eligible children under age 15.
- Once every two years per permanent first and second molars.

Not Covered:

- Sealants for primary teeth, wisdom teeth, or teeth that have already been treated with a restoration.

See Also:

Additional Condition-Specific Dental Benefits later in this section.

Space Maintainers

Covered: For extracted primary posterior (back) teeth to maintain position of teeth for stabilization or activate movement of teeth.

Benefits Maximum:

- For eligible children under age 15.
- Once every two years.

Not Covered:

- Replacement space maintainers.
- Repair or replacement of lost/broken appliances.

X-rays

Covered:

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

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

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

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

Benefits Maximum:

- Bitewing x-rays twice per benefit year.
- Full mouth (panoramic) x-rays once every three years.

Basic Restorative Services

Anesthesia

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

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

See Also:

Pretreatment Notification, page 25.

Cavity Repair

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

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

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

Not Covered:

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

See Also:

Pretreatment Notification, page 25.

Emergency Treatment (Palliative)

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

See Also:

Additional Condition-Specific Dental Benefits later in this section.

Occlusal Adjustment

Covered:

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

Not Covered:

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

See Also:

Pretreatment Notification, page 25.

Posterior Composites

Covered: Composite (resin-based) tooth-colored fillings to restore defects in the structure of a back (posterior) tooth.

Benefits Maximum:

- Benefits are limited to the amount paid for a silver (amalgam) filling. You are responsible for any difference in cost between the composite filling and a silver filling to restore a back tooth.

See Also:

Pretreatment Notification, page 25.

Oral Surgery

Oral Surgery

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

Basic Extractions

- Extraction of erupted tooth or exposed root.
- Removal of primary teeth.

Complex Extractions

- Surgical removal of erupted tooth.
- Surgical removal of impacted tooth.
- Surgical removal of residual tooth roots.
- Surgical removal of third molars when the removal is associated with symptoms or oral pathology.

Complex Surgical Procedures

- Alveoloplasty.
- Removal of exostosis-per site.
- Surgical reduction of osseous tuberosity.
- Vestibuloplasty.

Brush Biopsy

A tissue test of the mouth's surface for possible cancer.

Not Covered:

- Surgical exposure of impacted or unerupted tooth for orthodontic reasons.
- Surgical repositioning of teeth.

See Also:

Pretreatment Notification, page 25.

Endodontics

Apicoectomy/Periradicular Surgery

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

Benefits Maximum:

- Once every two years per tooth.

See Also:

Pretreatment Notification, page 25.

Pulp Caps

Covered:

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

Benefits Maximum:

- Direct pulp caps are a benefit once every two years per tooth.

Not Covered:

- **Indirect.** Services and supplies associated with treatment of pulp that is not exposed.

See Also:

Pretreatment Notification, page 25.

Pulpotomy

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

Benefits Maximum:

- Pulpotomy is a benefit once every two years per tooth.

Not Covered:

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

See Also:

Pretreatment Notification, page 25.

Retrograde Fillings

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

Benefits Maximum:

- Once every two years per tooth.

See Also:

Pretreatment Notification, page 25.

Root Canals

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

Benefits Maximum:

- Once every two years per tooth.

Not Covered:

- Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
- Intentional reimplantation.
- Incomplete root canals.

See Also:

Pretreatment Notification, page 25.

Periodontics

Periodontal Procedures

Covered:

- **Non-Surgical Procedures (Root Planing and Scaling).** Removing contaminants such as bacterial plaque and tartar (calculus) from a tooth root to prevent or treat disease of the gum tissues and bone that support it.
- **Complex Surgical Procedures.** Various surgical interventions designed to repair and regenerate gum and bone tissues that support the teeth.

Benefits Maximum:

- Non-surgical periodontal procedures are a benefit once every two years.
- Complex surgical periodontal procedures are a benefit once every two years for each quadrant.

See Also:

Pretreatment Notification, page 25.

Major Restorative Services

Crowns

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

Benefits Maximum:

- Crowns are a benefit once every five years.
- If a filling was performed on the same tooth within the previous 12 months, the benefit for the crown will be reduced by the amount of the benefit paid for the filling.
- If an onlay was performed on the same tooth within the past five years, you do not have benefits for a crown.

Not Covered:

- Temporary, provisional, or interim crowns.
- Anatomical crown exposure.
- Permanent crowns when the tooth does not have decay, fracture, or has been endodontically treated.

See Also:

Pretreatment Notification, page 25.

Inlays

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

Benefits Maximum:

- Available once every five years.
- Benefits are limited to the amount paid for a silver (amalgam) filling. You are responsible for any difference in cost between a gold, porcelain, or composite filling and a silver filling.

- If a filling was performed on the same tooth within the previous 12 months, the benefit for the inlay will be reduced by the amount of the benefit paid for the filling.
- Recementing is a benefit six months after initial placement of the permanent inlay.

See Also:

Pretreatment Notification, page 25.

Onlays

Covered: Restoring tooth structure lost due to decay or fracture by replacing one or more missing or damaged biting cusps of a tooth with an indirect fabrication when the tooth cannot be restored with a silver (amalgam) or tooth-colored (composite) filling.

Benefits Maximum:

- Onlays are a benefit once every five years.
- If a filling was performed on the same tooth within the previous 12 months, the benefit for the onlay will be reduced by the amount of the benefit paid for the filling.
- Recementing is a benefit six months after initial placement.
- If a crown was performed on the same tooth within the past five years, you do not have benefits for an onlay.

Not Covered:

Onlays when the tooth does not have decay, fracture, or when the tooth has been endodontically treated.

See Also:

Pretreatment Notification, page 25.

Posts and Cores

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

Benefits Maximum:

- Benefits for a restorative cast post and core build-up, including one post per tooth and one pin per surface, are allowed once every five years when necessary to retain an indirectly fabricated restoration.

See Also:

Pretreatment Notification, page 25.

Prosthodontics

Bridges

Covered: Replacement of missing permanent teeth with a dental prosthesis that is cemented in place and can only be removed by a dental provider. Bridges are covered when there are no other missing teeth in the same arch that have not been replaced with a removable partial denture. Bridge repairs and adjustments are also included.

Benefits Maximum:

- Bridges are a benefit once every five years for members age 16 or older when:
 - none of the teeth being replaced by the bridge were previously treated with a crown or cast restoration within the last five years;
 - five years have passed since the initial placement of the permanent bridge, and the existing bridge needs replacement because it cannot be repaired or adjusted.
- Bridge repairs are a benefit if performed six months or more after initial placement of the permanent bridge.
- Adjustments are a benefit if performed six months or more after initial placement of the permanent bridge and twice every 12 months thereafter.
- Recementing of a permanent bridge is a benefit once per benefit year.
- Bridges that are supported by dental implants are limited to the amount paid for a bridge supported by natural teeth.

- Single tooth implant body, abutment, and crown is a benefit once every five years per tooth for members age 16 or older.

Not Covered:

- Replacement of an existing partial with a bridge.
- Interim removable or fixed prosthetic appliances.
- Removable or fixed bridges when the placement of these prosthodontics is temporary, and a more permanent procedure is forthcoming.

See Also:

Pretreatment Notification, page 25.

Dentures

Covered: Replacing missing permanent teeth with a dental prosthesis that is removable. Denture repair, rebasing, and relining are also included.

Benefits Maximum:

- Dentures and partials are a benefit once every five years.
- Dentures that are supported by surgically placed dental implants are limited to the amount paid for a conventional prosthesis supported by natural teeth.
- Relining is a benefit if performed six months or more after the initial placement of the permanent denture or partial and once every five years thereafter.
- Rebasing is a benefit if performed six months or more after the initial placement of the permanent denture or partial and once every five years thereafter.
- Tissue conditioning is a benefit once every three years.
- Denture and partial repairs are a benefit if performed six months or more after the initial placement of the permanent denture or partial.
- Adjustments on permanent dentures and partials are a benefit if performed

six months or more after the initial placement of the permanent denture or partial and twice every 12 months thereafter. Dentures or partials may be eligible for replacement once every five years for members age 16 or older if the dentures or partials cannot be repaired or adjusted.

Not Covered:

- Interim removable or fixed prosthetic appliances.

See Also:

Pretreatment Notification, page 25.

Implants

Covered: Replacing a missing permanent tooth with a surgically-implanted dental prosthesis that is not removable by the patient. A restoration is then placed on the implant. Coverage includes only the single surgical placement of the implant body, implant abutment, and implant/abutment supported crown. Since some implant services may not be covered, a pretreatment estimate is recommended.

To be covered, implants must meet all of the following criteria:

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

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

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

Benefits Maximum:

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

Not Covered:

- Services or supplies related to a noncovered implant procedure.

See Also:

Pretreatment Notification, page 25.

Orthodontics

Orthodontics (Braces)

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

- Exposure of impacted or unerupted teeth.

Please note: Benefit payments are made in equal amounts:

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

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

Benefits Maximum:

- Covered for adults and for eligible children who are at least age eight.
- \$1,500 per lifetime per person.

Not Covered:

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

See Also:

Pretreatment Notification, page 25.

Additional Condition-Specific Dental Benefits

Additional condition-specific dental benefits may be available at no cost for members with the following conditions: pregnancy, Type 1 or Type 2 diabetes, heart disease, end-stage renal disease, head and neck cancer with chemotherapy or radiation, other cancers with chemotherapy, a stroke, organ transplant, or a suppressed immune system (HIV/AIDS).

A member who is pregnant is eligible for additional benefits up to 90 days beyond the expected due date. A member diagnosed with Type 1 or Type 2 diabetes, heart disease, end-stage renal disease, head and neck cancer with chemotherapy or radiation, other cancers with chemotherapy, a stroke, organ transplant, or a suppressed immune system (HIV/AIDS) is eligible for additional benefits every benefit year until coverage under this dental plan ends.

Additional condition-specific dental benefits include the following procedures:

- One additional dental cleaning (prophylaxis).
- One additional fluoride application (topical). * Age limitations, if applicable, are also removed.*
- One additional oral evaluation.
- Emergency treatment (palliative).
- One additional periodontal root planing and scaling per quadrant.
- Periodontal maintenance benefits.
- *Age limitations, if applicable, are removed for sealant applications.

*The additional condition-specific dental benefit is only available for members with the following conditions: pregnancy, end stage renal disease, head and neck cancer with chemotherapy or radiation, other cancers with chemotherapy, or organ transplant.

To obtain the additional condition-specific dental benefits, you must complete the Extra Dental Benefits Enrollment Form

found at Wellmark.com/member/forms, or by calling the Customer Service number listed on the back of your ID card. Submit the form by mail or fax to:

Wellmark Blue Cross and Blue Shield
P.O. Box 9354
Des Moines, IA 50306-9354
Fax: **515-558-7762**

The additional condition-specific dental benefits will be available the date we receive the Extra Dental Benefits Enrollment Form.

Please note: Additional condition-specific dental benefits count toward the Benefit Year Maximum.

Dental Services that are Not Covered

Dental services not covered include, but are not limited to:

- Dental services completed prior to the date you became eligible for coverage.
- Services of anesthesiologists.
- Anesthesia services, except by a dentist or by an employee of the dentist when the service is performed in their office and by a dentist or an employee of the dentist who is certified in their profession to provide anesthesia services.
- Dental services performed by someone other than a licensed dentist, licensed physician, or their employees.
- Non-dental services which include but are not limited to, telephone consultations, case presentations, charges for missed appointments, charges for completion of any form, or charges for information. You are also not covered for services delivered to you by a practitioner via real-time, interactive audio only, audio-visual technology, or web-based mobile-device or similar electronic-based communication network.
- Dental services, appliances, or restorations that are necessary to alter, restore, or maintain occlusion, including

but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting, and gnathologic recordings.

- Services or supplies used for localized delivery of antimicrobial agents or biologic modifiers into diseased crevices around your teeth to aid in soft tissue or bone tissue regeneration.
- Artificial material implanted or grafted into or onto bone tissue or soft tissue, including implant services and associated fixtures, or surgical removal of implants.
- Any material grafted onto bone tissue or soft tissue, including procedures necessary for guided tissue regeneration.
- Incomplete, interim, or temporary services.
- Services and supplies associated with retreatment of endodontic services that were previously covered under this dental plan.
- Removal of pulpal debridement, pulp cap, post, pin(s), resorbable or non-resorbable filling material(s) and the procedures used to prepare and place material(s) in the canals (root).
- Procedures designed to enable prosthetic or restorative services to be performed, such as a crown lengthening.
- Cytology sample collection.
- Separate services billed when they are an inherent component of a dental service.
- Additional, elective, or enhanced prosthodontic procedures including, but not limited to, connector bar(s), stress breakers, and precision attachments.
- Placement or removal of sedative filling, base, or liner used under a restoration.
- Services or supplies that are medical in nature, including, but not limited to, dental services performed in a hospital and treatment of fractures or dislocations, cysts, malignancies, temporomandibular joint disorder, or accidental injuries.
- Services or supplies for the correction of congenital deformities such as cleft palate.
- Services or supplies that have the primary purpose of improving the appearance of your teeth, rather than restoring or improving dental form or function. This includes, but is not limited to, enamel microabrasion, odontoplasty, whitening agents, veneers, and tooth bonding.
- Prescription or non-prescription drugs or medicines.
- Pulp vitality tests.
- Adjunctive diagnostic tests.
- Diagnostic casts.
- Cone beam images.
- Temporary anchorage devices.
- Sinus augmentation.
- Separate charges for “infection control,” which includes the costs for services and supplies associated with sterilization procedures. Payment to participating dental providers includes infection control costs and participating dental providers are not allowed to charge an additional fee for “infection control.”
- Dental appliances and mouth guards including, but not limited to, athletic guards and bite guards to reduce bite (occlusal) trauma due to tooth grinding or jaw clenching. The repair or replacement of broken, lost, or stolen dental appliances and mouth guards, including related services or supplies, are also not covered.
- Bacteriologic tests for determination of periodontal disease or pathologic agents.
- Provisional splinting, temporary procedures, or interim stabilization of teeth.
- Veneers—a layer of tooth-colored material typically made of composite, porcelain, ceramic or acrylic resin that is attached to the tooth surface by direct

fusion, cementation, or mechanical retention. Veneers may also refer to a restoration that is sealed to the facial surface of a tooth.

- Orthodontic treatment unless specified in this dental plan as a covered benefit.

4. General Conditions of Coverage, Exclusions, and Limitations

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

Conditions of Coverage

Dentally Necessary and Appropriate

A key general condition in order for you to receive benefits for any dental service is that it must be dentally necessary and dentally appropriate. Even a service listed as otherwise covered in *Details - Covered and Not Covered* may be excluded if it is not dentally necessary and appropriate in the circumstances. Unless otherwise required by law, Wellmark determines whether a service is dentally necessary and appropriate, and that decision is final and conclusive. Benefits are available only if the services are dentally necessary services and are covered services under this coverage manual. Even though a dental provider may recommend a dental procedure or supply, it may not be dentally necessary and appropriate.

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

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

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

- The treatment is consistent with and meets professionally recognized standards of dental care and complies with criteria adopted by Wellmark in terms of type, frequency, setting, timing,

duration, and is considered effective for your symptoms and diagnosis.

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

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

Member Eligibility

Another general condition of coverage is that the person who receives services must meet requirements for member eligibility. See *Coverage Eligibility and Effective Date*, page 29.

General Exclusions

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

Complications of a Noncovered Service or Services Related to Noncovered Services

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

Services, supplies, or devices that are administered primarily to support the provision or receipt of noncovered services are also not covered.

Nondental Services

You are not covered for services including, but not limited to: telephone consultations, charges for failure to keep scheduled appointments, charges for completion of any form, or charges for dental information. You are also not covered for services

delivered to you by a practitioner via real-time, interactive audio only, audio-visual technology, or web-based mobile device or similar electronic-based communication network.

Covered by Other Programs or Laws

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

- Someone else has the legal obligation to pay for services, has an agreement with you to not submit claims for services or, without this group health plan, you would not be charged.
- You require services or supplies for an illness or injury sustained while on active military status.

Benefit Limitations

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

- A service or supply that is not covered under this group health plan is your responsibility.
- If a covered service or supply reaches a benefits maximum, it is no longer eligible for benefits. (A maximum may renew at the next benefit year.) See *Details – Covered and Not Covered*, page 11.
- The type of provider you choose can affect your benefits and what you pay. See *Choosing a Provider*, page 23, and *Factors Affecting What You Pay*, page 27. An example of a charge that depends on the type of provider includes, but is not limited to:
 - Any difference between the provider's amount charged and our amount paid is your responsibility if you receive services from an Out-of-Network dental provider.

5. Choosing a Provider

Choosing a Dental Provider

Your dental benefits are called Blue Dental PPO. Dental providers who participate with the network utilized by these dental benefits and dental providers outside the Blue Dental PPO service area who participate in a PPO network with entities whom Wellmark has agreements with are called PPO dental providers.

Dental providers who are not Blue Dental PPO providers are called Participating or Out-of-Network providers.

To determine if a dental provider is a PPO dental provider, ask your dental provider, refer to our online *Blue Dental PPO Provider Directory* at Wellmark.com/finder or call the Customer Service number on your ID card.

Blue Dental PPO allows you to receive covered services from almost any dental provider you choose. However, you will usually pay less for services received from Blue Dental PPO providers. We recommend you:

- Go to a Blue Dental PPO provider whenever possible.
- Always present your ID card when receiving services.

Advantages of Visiting Blue Dental PPO and Participating Dental Providers

- You will usually pay less for services. You typically pay the least for services received from PPO dental providers. An Out-of-Network dental provider's charge for a service may be more than the amount we will cover. You are responsible for this difference from an Out-of-Network dental provider.
- Claims from PPO or Participating dental providers are filed for you. If you visit an Out-of-Network dental provider, you are responsible for filing the claim.

- Blue Dental PPO and Participating dental providers handle pretreatment notification for you.

6. Pretreatment Notification

Pretreatment Notification of Dental Services

Purpose	Pretreatment notification helps us determine whether certain planned dental procedures are covered benefits. A pretreatment plan describes your dental provider's recommended procedure and its estimated cost. Pretreatment notification is recommended.
Applies to	Basic Restorative Services (cavity repair) Oral Surgery Endodontics (root canals and pulp treatments) Periodontics (gum and bone disease) Major Restorative Services (crowns) Prosthodontics (dentures and bridges) Orthodontics (braces)
Person Responsible	PPO and Participating dental providers submit a pretreatment plan for you. You need to submit a pretreatment plan if your dental provider is Out-of-Network.
Process	<p>Wellmark will review the treatment plan; however, the lack of a pretreatment estimate will not affect your benefits. If a service is dentally necessary and appropriate and is a benefit of your Blue Dental PPO benefits, it will be covered according to the terms and limitations described in this coverage manual.</p> <p>A complete pretreatment estimate includes the plan of treatment, x-rays, diagnostic charts, and other documentation when applicable. Send the pretreatment plan with x-rays and supporting information to:</p> <p style="padding-left: 40px;">Wellmark Blue Cross and Blue Shield of Iowa P.O. Box 9354 Des Moines, IA 50306-9354</p> <p>Once we receive the pretreatment plan, we will inform you and your dental provider within 15 working days whether the services are covered. We will either accept the pretreatment plan as submitted or deny it because procedures are not a benefit.</p>

7. Factors Affecting What You Pay

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

Benefit Year

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

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

The benefit year is important for calculating:

- Deductible.
- Benefits maximum.
- Benefit year carryover.

PPO and Participating vs. Out-of-Network Dental Providers

Wellmark sends claim payments directly to PPO and Participating dental providers. Wellmark does not send payments directly to Out-of-Network dental providers. If you receive services from an Out-of-Network dental provider, Wellmark will send payment to you, and you are responsible for ensuring that the dental provider is paid in full. We do not have contracts with Out-of-Network dental providers, and they do not agree to accept our payment arrangements. If you visit an Out-of-Network dental

provider, you will be responsible for any difference between the Out-of-Network dental provider's amount charged and the maximum allowable fee.

Amount Charged and Maximum Allowable Fee

Amount Charged

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

Maximum Allowable Fee

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

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

- The frequency of the determination of the maximum allowable fee.
- A general description of the methodology used to determine the maximum allowable fee, including geographic locations.

The maximum allowable fee may be less than the amount charged for the service or supply. You are responsible for this difference if you receive covered services from an Out-of-Network dental provider.

Payment Arrangements

Wellmark has contracting relationships with participating Blue Dental PPO providers. To make services available on a similar basis

outside Iowa, we have agreements with entities who have their own dental networks. We use different methods to determine payment arrangements. These payment arrangements usually result in savings.

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

8. Coverage Eligibility and Effective Date

Eligible Members

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

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

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

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

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

- Under age 26.
- An unmarried full-time student enrolled in an accredited educational institution. Full-time student status continues during:
 - Regularly-scheduled school vacations; and
 - Medically necessary leaves of absence until the earlier of one year from the first day of leave or the date coverage would otherwise end.
- An unmarried child who is deemed disabled. The disability must have

existed before the child turned age 26 or while the child was a full-time student. Wellmark considers a dependent disabled when they meet the following criteria:

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

Documentation will be required.

Please note: In addition to the preceding requirements, eligibility is affected by coverage enrollment events and coverage termination events. See *Coverage Change Events*, page 33.

When Coverage Begins

Coverage begins on the member's effective date. If you have just started a new job, or if a coverage enrollment event allows you to add a new member, ask your employer or group sponsor about your effective date. Services received before the effective date of coverage are not eligible for benefits.

Late Enrollees

A late enrollee is a member who declines coverage when initially eligible to enroll and then later wishes to enroll for coverage. However, a member is not a late enrollee if a qualifying enrollment event allows enrollment as a special enrollee, even if the enrollment event coincides with a late enrollment opportunity. See *Coverage Change Events*, page 33.

A late enrollee may enroll for coverage at any time.

Changes to Information Related to You or to Your Benefits

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

Qualified Medical Child Support Order

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

A QMCSO specifies information such as:

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

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

The order and the notice given by the employer or group sponsor will provide

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

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

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

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

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

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

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

- You or your spouse no longer pay the cost of coverage because the employer or

group sponsor no longer owes
compensation; or

- You or your spouse have terminated employment with the employer and have not elected to continue coverage.

9. Coverage Changes and Termination

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

Coverage Change Events

Coverage Enrollment Events: The following events allow you or your eligible child to enroll for coverage. The following events may also allow your spouse to enroll for coverage if spouses are eligible for coverage under this plan.

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

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

- Dependent child resumes status as a full-time student.
- Addition of a biological child by court order. See *Qualified Medical Child Support Order*, page 30.
- Appointment as a child's legal guardian.
- Placement of a foster child in your home by an approved agency.

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

- Death.
- Divorce or annulment (if spouses are eligible for coverage under this plan).

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

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

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

Reinstatement of Child

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

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

Reinstatement Requirements. A request for reinstated coverage for a child

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

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

Requirement to Notify Group Sponsor

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

- A birth, adoption, or placement for adoption.
- Divorce, legal separation, or annulment.
- Your dependent child loses eligibility for coverage.
- You lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) (the *hawk-i* plan in Iowa).
- You become eligible for premium assistance under Medicaid or CHIP.

For all other events, your employer or group sponsor must allow a minimum of 30 days for notification of an event that allows you to add members or make changes to the coverage status of members. See your employer or group sponsor for details.

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

Coverage Termination

The following events terminate your coverage eligibility.

- You become unemployed when your eligibility is based on employment.

- You become ineligible under your employer's or group sponsor's eligibility requirements for reasons other than unemployment.
- Your employer or group sponsor discontinues or replaces this group health plan.
- We decide to terminate or discontinue offering this plan by giving written notice to your employer or group sponsor.

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

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

Fraud or Intentional Misrepresentation of Material Facts

Your coverage will terminate immediately if:

- You use this group health plan fraudulently or intentionally misrepresent a material fact in your application; or
- Your employer or group sponsor commits fraud or intentionally misrepresents a material fact under the terms of this group health plan.

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

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

- We will retain legal rights, including the right to bring a civil action.

Nonpayment

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

Any payment(s) remitted to Wellmark that are returned by the bank account holder's bank as unpaid will be subject to a returned payment fee. The bank account holder will be responsible for this fee.

The terms of reinstatement will require payment of a reinstatement fee. The notice will detail the amount due and the final deadline for the reinstatement payment to be made.

Coverage Continuation

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

COBRA Continuation

The federal Consolidated Omnibus Budget Reconciliation Act (COBRA) applies to most non-governmental employers with 20 or more employees. Generally, COBRA entitles you and eligible dependents to continue coverage if it is lost due to a qualifying event, such as employment termination, divorce, or loss of dependent status. You and your eligible dependents will be required to pay for continuation coverage. Other federal or state laws similar to COBRA may apply if COBRA does not. Your employer or group sponsor is required to provide you with additional information on continuation coverage if a qualifying event occurs.

10. Claims

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

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

When to File a Claim

You need to file a claim if you:

- Use a provider who does not file claims for you. PPO and Participating dental providers file claims for you.

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

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

How to File a Claim

All claims must be submitted in writing.

1. Get a Claim Form

Forms are available at Wellmark.com/member/forms or by calling the Customer Service number on your ID card or from your personnel department. If you call Customer Service to request that a claim form be mailed to you, please allow up to 10 business days for delivery.

2. Fill Out the Claim Form

Follow the same claim filing procedure regardless of where you received services. Directions are printed on the back of the claim form. Complete all sections of the claim form. For more efficient processing,

all claims (including those completed out-of-country) should be written in English.

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

Dental Claim Form. Follow these steps to complete a dental claim form:

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

3. Sign the Claim Form

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

4. Submit the Claim

We recommend you retain a copy for your records. The original form you send or any

attachments sent with the form cannot be returned to you. Send the claim to:

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

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

Notification of Decision

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

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

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

If you have other insurance coverage, our processing of your claim may utilize coordination of benefits guidelines. See *Coordination of Benefits*, page 39.

11. Coordination of Benefits

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

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

Other Coverage

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

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

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

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

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

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

Your PPO or Participating dental provider will forward your coverage information to us. If you see an Out-of-Network dental provider, you are responsible for informing us about your other coverage.

Claim Filing

If you know that your other coverage has primary responsibility for payment, after you receive services, a claim should be submitted to your other insurance carrier first. If that claim is processed with an unpaid balance for benefits eligible under this group health plan, you or your provider should submit a claim to us and attach the other carrier's explanation of benefit payment within 180 days of the date of the other carrier's explanation of benefits. We may contact your provider or the other carrier for further information.

Rules of Coordination

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

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

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

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

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

- If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an employee, plan member, subscriber, policyholder or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the primary plan and the COBRA or state or other federal continuation coverage is the secondary plan. If the other plan does not have this rule and, as a result, the plans do not agree on the order of benefits, this rule is ignored.
- The coverage with the earliest continuous effective date pays first if none of the rules above apply.
- Benefits for dental services under your medical benefits plan are payable before benefits under your Blue Dental PPO benefits plan.

Dependent Children

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

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

coverage and the plan of that parent has actual knowledge of those terms, then that parent's coverage pays first. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's coverage pays first. This item does not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.

- If a court decree states that both parents are responsible for the child's health care expense or health care coverage or if a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or coverage of the dependent child, then the coverage of the parent whose birthday occurs first in a calendar year pays first. If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.
- If a court decree does not specify which parent has financial or insurance responsibility, then the coverage of the parent with custody pays first. The payment order for the child is as follows: custodial parent, spouse of custodial parent, other parent, spouse of other parent. A custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one-half of the calendar year excluding any temporary visitation.
- For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, as outlined previously in this *Dependent Children* section.

Effects on the Benefits of this Plan

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

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

Right of Recovery

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

12. Appeals

Right of Appeal

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

How to Request an Internal Appeal

You or your authorized representative, if you have designated one, may appeal an adverse benefit determination within 180 days from the date you are notified of our adverse benefit determination by submitting a written appeal. Appeal forms are available at our website, Wellmark.com/member/forms. See *Authorized Representative*, page 49.

You must make your request for a review in writing.

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

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

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

Where to Send Internal Appeal

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

Review of Internal Appeal

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

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

Decision on Internal Appeal

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

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

Arbitration and Legal Action

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

appeal procedure described in this section. See the *Arbitration and Legal Action* section and *Governing Law*, page 53, for important information about your arbitration and legal action rights after you have exhausted the appeal procedures in this section.

13. Arbitration and Legal Action

PLEASE READ THIS SECTION CAREFULLY

Mandatory Arbitration

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

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

Covered Claims

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

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

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

No Class Arbitrations and Class Actions Waiver

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

Claims Excluded from Mandatory Arbitration

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

AN ARBITRATOR DETERMINES A PARTICULAR CLAIM IS EXCLUDED FROM ARBITRATION BY FEDERAL OR STATE LAW, CLAIMS EXCLUDED BY APPLICABLE LAW, LATER IN THIS SECTION, AND GOVERNING LAW, PAGE 53, WILL APPLY TO THE PARTIES AND SUCH PARTICULAR CLAIM.

Arbitration Process Generally

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

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

Arbitration Fees and Other Costs

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

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

Confidentiality

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

Questions of Arbitrability

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

Claims Excluded By Applicable Law

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

- You shall not bring any legal or equitable action against us because of a health benefit claim under this plan, or because of the alleged breach of this plan, more than two years after the end of the calendar year in which the services or supplies were provided.
- Any action brought because of a Claim under this plan will be litigated in the state or federal courts located in the state of Iowa and in no other.
- **YOU AND WE BOTH WAIVE ANY RIGHT TO A JURY TRIAL WITH RESPECT TO AND IN ANY CLAIM.**
- **FURTHER, YOU AND WE BOTH WAIVE ANY RIGHT TO SEEK OR RECOVER PUNITIVE OR EXEMPLARY DAMAGES WITH RESPECT TO ANY CLAIM.**

Survival and Severability of Terms

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

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

14. General Provisions

Contract

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

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

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

Interpreting this Coverage Manual

We will interpret the provisions of this coverage manual 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 coverage manual. If any benefit described in this coverage manual is subject to a determination of dental 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 coverage manual. You should become familiar with the entire document.

Authority to Terminate, Amend, or Modify

Your employer or group sponsor has the authority to terminate, amend, or modify the coverage described in this coverage manual at any time. Any amendment or

modification will be in writing and will be as binding as this coverage manual. If your contract is terminated, you may not receive benefits.

Authorized Group Benefits Plan Changes

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

- Written amendment signed by an authorized officer and accepted by you or your employer or group sponsor.
- Our receipt of proper notification that an event has changed your spouse or dependent's eligibility for coverage. See *Coverage Changes and Termination*, page 33.

Authorized Representative

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

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

Release of Information

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

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

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

Privacy of Information

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

Treatment

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

Payment

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

Health Care Operations

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

Other Disclosures

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

Member Health Support Services

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

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

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

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

Value Added or Innovative Benefits

Wellmark may, from time to time, make available to you certain value added or innovative benefits for a fee or for no fee. These value added or innovative benefits are not insurance and may be changed or eliminated at any time. Examples include Blue365[®], identity theft protections, and discounts on alternative/preventive therapies, fitness, exercise and diet assistance, and elective procedures as well as resources to help you make more informed health decisions. Wellmark may also provide rewards or incentives under this plan if you participate in certain voluntary wellness activities or programs that encourage healthy behaviors. Your employer is responsible for any income and employment tax withholding, depositing and reporting obligations that may apply to the value of such rewards and incentives.

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 coverage manual means that your group sponsor has modified your group health plan documents to incorporate this provision, and has provided certification of compliance to Wellmark.

Purpose of Disclosure to Group Sponsor

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

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

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

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

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

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

protected health information and electronic protected health information.

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

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

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

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

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

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

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

return or destroy all of the protected health information, your group sponsor will limit the use or disclosure of protected health information it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.

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

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

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

Adequate Separation Between the Group Sponsor and the Group Health Plan

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

These individuals will have access to protected health information only to perform the plan administration functions

that the group sponsor provides for the group health plan.

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

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

Nonassignment

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

Governing Law

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

Medicaid Enrollment and Payments to Medicaid

Assignment of Rights

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

Enrollment Without Regard to Medicaid

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

Acquisition by States of Rights of Third Parties

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

Medicaid Reimbursement

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

Payment in Error

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

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

Notice

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

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

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

Consent to Telephone Calls and Text or Email Notifications

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

Glossary

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

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

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

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

Group Health Plan. For purposes of this dental coverage manual, the term group health plan represents your dental benefits plan.

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

Member. A person covered under this group health plan.

Out-of-Network Dental Provider. A dental provider who does not participate with an entity whom Wellmark is affiliated.

Participating Dental Provider. A dental provider who participates with Wellmark or with entities whom Wellmark is affiliated with, but not with a PPO network.

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

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

PPO Dental Provider. A dental provider who participates with Blue Dental PPO, or a dental provider outside the Blue Dental PPO service area who participates in a PPO network with an entity with whom Wellmark is affiliated.

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

Services or Supplies. Any services, supplies, treatments, or devices, as applicable in the context of this coverage manual, that may be used to diagnose or treat a dental condition.

Spouse. A man or woman lawfully married to a covered member.

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

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

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- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
 - Qualified interpreters
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If you believe that Wellmark has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Wellmark Civil Rights Coordinator, 1331 Grand Avenue, Station 3E417, Des Moines, IA 50309-2901, 515-376-6500, TTY 888-781-4262, Fax 515-376-9055, Email CRC@Wellmark.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Wellmark Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

ATENCIÓN: Si habla español, los servicios de asistencia de idiomas se encuentran disponibles gratuitamente para usted. Comuníquese al 800-524-9242 o al (TTY: 888-781-4262).

注意: 如果您说普通话, 我们可免费为您提供语言协助服务。请拨打 800-524-9242 或 (听障专线: 888-781-4262)。

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NAPOMENA: Ako govorite hrvatski, dostupna Vam je besplatna podrška na Vašem jeziku. Kontaktirajte 800-524-9242 ili (tekstualni telefon za osobe oštećena sluha: 888-781-4262).

ACHTUNG: Wenn Sie deutsch sprechen, stehen Ihnen kostenlose sprachliche Assistenzdienste zur Verfügung. Rufnummer: 800-524-9242 oder (TTY: 888-781-4262).

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ማሳሰቢያ: ለማርኛ የሚናገሩ ስዊድን ገቢዎች ለገንጠሎች: ከከፍተኛ የገንዘብ በ 800-524-9242 ወይም (በTTY: 888-781-4262) ጻውሰው ያነጋግሩ::

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