From: BWilley@crst.com
Sent: Tuesday, October 19, 2010 11:30 AM
To: HHS HealthInsurance (HHS)
Cc: jbarnes@crst.com
Subject: Waiver Application - CRST International

Attachments: CRST Waiver Application.pdf; CRST International Bridge Plan L3V 010110.pdf; Bridge Enrollment Guide.pdf

Attn: James Mayhew - Health and Human Services, Office of Consumer Information and Insurance Oversight

Dear Mr. Mayhew:
Attached please find the application for a waiver from CRST International, Inc.

Kind regards,

Brooke Willey, VP - Human Resources
CRST International, Cedar Ra
direct: 319/390-2856 cell: (b)(6)

Brooke Willey, VP – Human Resources
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3930 – 16th Avenue SW
Cedar Rapids, IA 52404

Office Phone 319/390-2856
Office Fax 319/731-3954

October 15, 2010

Health & Human Services
Office of Consumer Information and Insurance Oversight
Room 737-F-04
200 Independence Ave. SW
Washington, DC 20201

Attention: James Mayhew

RE: Annual Limits Waiver

Dear Mr. Mayhew:
CRST International Inc. is one of the nation's lead___long haul truckload carriers. Currently, CRST offers to employee drivers a group medical benefit plan that they are eligible to enroll in after (b)(4) days of full time employment. In order to assist our drivers during this waiting period CRST has offered a "***Bridge Plan"*** since January 2002. Our current B*ridge Plan* covers the drivers from their first day of hire and is intended to assist them and their family members with medical care during their waiting period. Upon satisfying the (b)(4) day waiting period, drivers are given the option to enroll in our group plan that will meet the PPACA requirements. We would also like to note CRST currently credits the *Bridge Plan* as credible coverage when they enroll in our group major medical plan.

A summary of the terms of our *bridge plan are as follows;* (a copy of our enrollment guide and coverage manual is included for your review);

Network and Admi_____s Blue Cross Blue Shield
Lifetime Maximum (b)(4)
Single Deductible (b)(4)
Family Deductible (b)(4)
Office Visit Copay (b)(4) Deductible waived
Inpatient/Outpatient Services (b)(4)% coinsurance after deductible

Currently our bridge plan covers (b)(4) employee drivers and represents over (b)(4) total individuals. We have averaged over (b)(4) drivers monthly for the last two years. Our annualized claims payments for 2010 are averaging over $(b)(4) which is in line with our two year average claims expense.

Our annual limit on this bridge plan is the same as our lifetime limit, (b)(4). However, this lifetime limit is intended to be in place for only (b)(4) days while the driver is in the waiting period for our group plan to take effect. The monthly premium for the bridge plan is (b)(4) for single coverage and (b)(4) for family coverage.

If CRST International's *Bridge Plan* is not granted a waiver to continue operating the plan as we have since 2002 we will most likely terminate the plan and the coverage to over (b)(4) employee drivers and their families which represents over (b)(4) in annual claims expenditures yearly. We know how much our employees rely on this coverage and utilize this plan while they are waiting to enroll in our major medical group offering.

With my signature below as Plan Administrator of CRST International, I herby attest to the following;

1) That the plan was in force prior to September 23, 2010; and
2) That the application of restricted annual limits to such plans or policies would result in a significant decrease in access to benefits for those currently covered by such plans or policies.

We appreciate your attention to this matter.

Sincerely,

Brooke Willey
Vice President, Human Resources
CRST International, Inc., Plan Administrator

Category	Covered	Not Covered	See Page	Service Maximum
Podiatrists	●		17	
Psychologists	●		17	
Speech Pathologists	●		17	
Prescription Drugs	●		17	
Preventive Care	●		18	Mammograms according to the following schedule unless recommended more frequently by your physician: ■ For women 35-39 years of age: (b)(4) (b)(4) ■ For women 40-49 years of age: (b)(4) (b)(4) ■ For women 50 years of age and older: (b)(4) (b)(4)
Prosthetic Devices	●		19	
Reconstructive Surgery	●		19	
Self Help Programs		⊘	19	
Sleep Apnea Treatment	●		19	
Speech Therapy	●		19	
Supplemental Accidental Injury Benefit	●		20	
				(b)(4) per accident.
Surgery	●		20	
Temporomandibular Joint Disorder (TMD)	●		20	
Transplants		⊘	20	
Travel or Lodging Costs		⊘	20	
Vision Services (related to an illness or injury)	●		20	
Wigs or Hairpieces		⊘	20	
X-ray and Laboratory Services	●		20	

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

Acupuncture Treatment

Not Covered: Acupuncture and acupressure treatment.

Allergy Testing and Treatment

Covered.

Ambulance Services

Covered: Professional air and ground ambulance transportation to a hospital or nursing facility in the surrounding area where your ambulance transportation originates.

All of the following are required to qualify for benefits:

- No other method of transportation is appropriate.
- The services required to treat your illness or injury are not available in the facility where you are currently receiving care if you are an inpatient at a facility.
- You are transported to the nearest hospital or nursing facility with adequate facilities to treat your medical condition.

See Also:

Transplants later in this section.

Anesthesia

Covered: Anesthesia and the administration of anesthesia.

Not Covered: Local or topical anesthesia billed separately from related surgical or medical procedures.

Blood Administration

Covered: Blood administration.

Not Covered: Blood. This exclusion does not apply to members with hemophilia.

Chemical Dependency Treatment

Not Covered.

Chemotherapy and Radiation Therapy

Covered: Use of chemical agents or radiation to treat or control a serious illness.

Cosmetic Services

Not Covered: Cosmetic services, supplies, or drugs unless provided primarily to restore function lost or impaired as the result of an illness, accidental injury, or a birth defect including treatment for any complications resulting from a noncovered cosmetic procedure.

See Also:

Reconstructive Surgery later in this section.

Counseling Services

Not Covered: Bereavement counseling or services (including volunteers or clergy), family counseling or training services, and marriage counseling or training services.

See Also:

Genetic Testing later in this section.

Dental Services

Covered:

- Dental treatment for accidental injuries when:

  - Treatment is completed within six months of the injury.
- Anesthesia (general) and hospital or ambulatory surgical facility services related to covered dental services if:
  - You are under age 14 and, based on a determination by a licensed dentist and your treating physician, you have a dental or developmental condition for which patient management in the dental office has been ineffective and requires dental treatment in a hospital or ambulatory surgical facility; or
  - Based on a determination by a licensed dentist and your treating physician, you have one or more medical conditions that would create significant or undue medical risk in the course of delivery of any necessary dental treatment or surgery if not rendered in a hospital or ambulatory surgical facility.
- Impacted teeth removal (surgical) as an inpatient or outpatient of a facility only when you have a medical condition (such as hemophilia) that requires hospitalization.
- Facial bone fracture reduction.
- Incisions of accessory sinus, mouth, salivary glands, or ducts.
- Jaw dislocation manipulation.
- Treatment of abnormal changes in the mouth due to injury or disease.

Not Covered:

- General dentistry including, but not limited to, diagnostic and preventive services, restorative services, endodontic services, periodontal services, indirect fabrications, dentures and bridges, and orthodontic services.
- Injuries associated with or resulting from the act of chewing.
- Maxillary or mandibular tooth implants (osseointegration).

Dialysis

Covered: Removal of toxic substances from the blood when the kidneys are unable to do so when provided as an inpatient in a hospital setting or as an outpatient in a Medicare-approved dialysis center.

Education Services for Diabetes

Not Covered: Diabetes education programs.

Emergency Services

Covered: When treatment is for a medical condition manifested by acute symptoms of sufficient severity, including pain, that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect absence of immediate medical attention to result in:

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

In an emergency situation, if you cannot reasonably reach a PPO provider, covered services will be reimbursed as though they were received from a PPO provider. However, because we do not have contracts with nonparticipating providers and they may not accept our payment arrangements, you are responsible for any difference between the amount charged and our amount paid for a covered service.

See Also:

Nonparticipating providers, page 36.

Fertility Services

Covered:

- Fertility prevention, such as tubal ligation (or its equivalent) or vasectomy (initial surgery only).

Genetic Testing

Covered: Genetic molecular testing (specific gene identification) and related counseling are covered when both of the following requirements are met:

- You are an appropriate candidate for a test under medically recognized standards (for example, family background, past diagnosis, etc.).
- The outcome of the test is expected to determine a covered course of treatment or prevention and is not merely informational.

See Also:

Prior Approval, page 30.

Hearing Services

Covered:

- Hearing examinations, but only to test or treat hearing loss related to an illness or injury.

Not Covered:

- Hearing aids.
- Routine hearing examinations.

Home Health Services

Covered: All of the following requirements must be met in order for home health services to be covered:

- You require a medically necessary skilled service such as skilled nursing, physical therapy, or speech therapy.
- Services are received from an agency accredited by the Joint Commission for Accreditation of Health Care Organizations (JCAHO) and/or a Medicare-certified agency.
- Services are prescribed by a physician and approved by our case manager for the treatment of illness or injury.
- Services are not more costly than alternative services that would be effective for diagnosis and treatment of your condition.
- The care is prescribed by a physician and approved by a Wellmark case manager.

The following are covered services and supplies:

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

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

Inhalation Therapy.

Medical Equipment.

Medical Social Services.

Medical Supplies.

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

Oxygen and Equipment for its administration.

Parenteral and Enteral Nutrition.

Physical Therapy.

Prescription Drugs and Medicines administered in the vein or muscle.

Prosthetic Devices and Braces.

Speech Therapy.

Not Covered: Custodial home care services and supplies, which help you with your daily living activities. This type of care does not require the continuing attention and assistance of licensed medical or trained paramedical personnel. Some examples of custodial care are assistance in walking and getting in and out of bed; aid in bathing, dressing, feeding, and other forms of assistance with normal bodily functions; preparation of special diets; and supervision of medication that can usually be self-administered. You are also not covered for sanitaria care or rest cures.

See Also:

Case Management, page 31.

Precertification, page 29.

Home/Durable Medical Equipment

Covered: Equipment that meets all of the following requirements:

- Durable enough to withstand repeated use.
- Primarily and customarily manufactured to serve a medical purpose.
- Used to serve a medical purpose.

In addition, we determine whether to pay the rental amount or the purchase price amount for an item, and we determine the length of any rental term. Benefits will never exceed the lesser of the amount charged or the maximum allowable fee.

See Also:

Medical and Surgical Supplies later in this section.

Orthotics later in this section.

Personal Convenience Items in the section *General Conditions of Coverage, Exclusions, and Limitations*, page 25.

Prosthetic Devices later in this section.

Prior Approval, page 30.

Hospice Services

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

Hospice respite care offers rest and relief help for the family caring for a terminally ill patient. Inpatient respite care can take place in a nursing home, nursing facility, or hospital. Hospice care must be precertified.

Service Maximum:

- (b)(4) **days** per lifetime for inpatient hospice respite care.
- (b)(4) **days** per lifetime for outpatient hospice respite care.
- Not more than (b)(4) **days** of hospice respite care at a time.

See Also:

Precertification, page 29.

Hospitals and Facilities

Covered: Hospitals and other facilities that meet standards of licensing, accreditation or certification. Following are some recognized facilities:

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

Hospital. This type of facility provides for the diagnosis, treatment, or care of injured or sick persons on an inpatient and outpatient basis. The facility must

be licensed as a hospital under applicable law.

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

Illness or Injury Services

Covered: Services or supplies used to treat any bodily disorder, bodily injury, disease, or mental health condition unless specifically addressed elsewhere in this section. This includes pregnancy and complications of pregnancy.

Treatment may be received from an approved provider in any of the following settings:

- Home.
- Inpatient (such as a hospital or nursing facility).
- Office (such as a doctor's office).
- Outpatient.

See Also:

Precertification, page 29.

Infertility Treatment

Not Covered:

- Infertility treatment if the infertility is the result of voluntary sterilization.
- Infertility treatment related to the collection or purchase of donor semen (sperm) or oocytes (eggs); freezing of sperm, oocytes, or embryos; surrogate parent services.
- Infertility diagnosis and treatment.
- Reversal of a tubal ligation (or its equivalent) or vasectomy.

Inhalation Therapy

Covered: Respiratory or breathing treatments to help restore or improve breathing function.

Maternity Services

Covered: Prenatal and postnatal care, delivery, including complications of pregnancy. A complication of pregnancy refers to a cesarean section that was not planned, an ectopic pregnancy that is terminated, or a spontaneous termination of pregnancy that occurs during a period of gestation in which a viable birth is not possible. Complications of pregnancy also include conditions requiring inpatient hospital admission (when pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy.

In accordance with federal or applicable state law, maternity services include a minimum of:

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

A practitioner is not required to seek Wellmark's review in order to prescribe a length of stay of less than 48 or 96 hours. The attending practitioner, in consultation with the mother, may discharge the mother or newborn prior to 48 or 96 hours, as applicable.

If the inpatient hospital stay is shorter, coverage includes a follow-up postpartum home visit by a registered nurse (R.N.). This nurse must be from a home health agency under contract with Wellmark or employed by the delivering physician.

See Also:

Coverage Change Events, page 43.

Medical and Surgical Supplies

Covered: Medical supplies and devices such as:

- Dressings and casts.
- Oxygen and equipment needed to administer the oxygen.
- Insulin syringes and supplies.

Not Covered:

- Elastic stockings or bandages including trusses, lumbar braces, garter belts, and similar items that can be purchased without a prescription.

See Also:

Home/Durable Medical Equipment earlier in this section.

Orthotics later in this section.

Prescription Drugs later in this section.

Personal Convenience Items in the section *General Conditions of Coverage, Exclusions, and Limitations*, page 25.

Prosthetic Devices later in this section.

Mental Health Services

Not Covered.

Morbid Obesity Treatment

Covered: Weight reduction surgery provided you meet eligibility criteria for age and medical condition and history. Not all procedures classified as weight reduction surgery are covered. Prior approval for weight reduction surgery is strongly recommended. For information on how to submit a prior approval request, refer to *Prior Approval* in the *Notification Requirements and Care Coordination* section of this coverage manual, or call the Customer Service number on your ID card. For the criteria we use to determine prior approval, you may call the Customer Service number on your ID card or visit our Web site at *www.wellmark.com*.

Not Covered:

- Weight reduction programs or supplies (including dietary supplements, foods, equipment, lab testing, examinations, and prescription drugs), whether or not weight reduction is medically appropriate.

See Also:

Prior Approval, page 30.

Motor Vehicles

Not Covered: Purchase or rental of motor vehicles such as cars or vans. You are also not covered for equipment or costs associated with converting a motor vehicle to accommodate a disability.

Musculoskeletal Treatment

Covered: Outpatient nonsurgical treatment of ailments related to the musculoskeletal system, such as manipulations or related procedures to treat musculoskeletal injury or disease.

Not Covered: Massage therapy.

Nonmedical Services

Not Covered: Such services as telephone consultations, charges for failure to keep scheduled appointments, charges for completion of any form, charges for medical information, and educational or recreational therapy or services or supplies that are nonmedical.

Occupational Therapy

Covered: Services are covered, but only those services to treat the upper extremities, which means the arms from the shoulders to the fingers.

Not Covered:

- Occupational therapy supplies.
- Occupational therapy provided as an inpatient in the absence of a separate medical condition that requires hospitalization.

Orthotics

Not Covered: Orthotic foot devices such as arch supports or in-shoe supports, orthopedic shoes, elastic supports, or examinations to prescribe or fit such devices.

See Also:

Home/Durable Medical Equipment earlier in this section.

Personal Convenience Items in the section *General Conditions of Coverage, Exclusions, and Limitations*, page 25.

Prosthetic Devices later in this section.

Over-the-Counter Products

Not Covered: Most over-the-counter products, including nutritional dietary supplements. However, certain over-the-counter products prescribed by a physician may be covered. To determine if a particular over-the-counter product is covered, call the Customer Service number on your ID card.

Physical Therapy

Covered.

Not Covered: Physical therapy provided as an inpatient in the absence of a separate medical condition that requires hospitalization.

Physicians and Practitioners

Covered: Most services provided by practitioners that are recognized by us and meet standards of licensing, accreditation or certification. Following are some recognized physicians and practitioners:

Advanced Registered Nurse Practitioners (ARNP). An ARNP is a registered nurse with advanced training in a specialty area who is registered with the Iowa Board of Nursing to practice in an advanced role with a specialty designation of certified clinical nurse specialist, certified nurse midwife, certified nurse practitioner, or certified registered nurse anesthetist.

Audiologists.

Chiropractors.

Doctors of Osteopathy (D.O.).

Licensed Independent Social Workers.

Medical Doctors (M.D.).

Occupational Therapists. This provider is covered only when treating the upper extremities, which means the arms from the shoulders to the fingers.

Optometrists.

Oral Surgeons.

Physical Therapists.

Physician Assistants.

Podiatrists.

Psychologists. Psychologists must have a doctorate degree in psychology with two years' clinical experience and meet the standards of a national register.

Speech Pathologists.

Not Covered:

- Athletic Trainers.
- Licensed Marriage and Family Therapists.
- Licensed Mental Health Counselors.

See Also:

Choosing a Provider, page 27.

Prescription Drugs

Covered:

- Prescription drugs and medicines received as an inpatient or outpatient of a facility.

A prescription drug is one that bears the legend, "Caution, Federal Law prohibits dispensing without a prescription."

Additional prescription drugs and medicines covered under this medical benefits plan include:

Drugs and Biologicals. Drugs and biologicals approved by the Food and Drug Administration. This includes such supplies as globulin, serum, vaccine, antitoxin, or antigen used in the prevention or treatment of disease.

Insulin.

Intravenous Administration. Intravenous administration of nutrients, antibiotics, and other drugs and fluids when provided in the home (home infusion therapy).

Self-Administered Injectable Drugs. Self-administered injectable drugs are generally covered under this medical benefits plan.

Not Covered:

- Prescriptions purchased from a retail pharmacy.

  Please note: Although your plan does not include benefits for prescription drugs at a pharmacy, you may save money when you use your ID card to fill prescriptions under your plan. Even though you must pay in full for any otherwise eligible prescription drug, the amount you pay at a participating pharmacy under this plan is the maximum allowable fee, which may be less than the charged amount that you would pay in the absence of your coverage. See Maximum Allowable Fee, in the Factors Affecting What You Pay section.
- Drugs purchased outside the United States.
- Contraceptive devices.
- Contraceptives absorbed through the skin.
- Implanted contraceptives.
- Injected contraceptives.
- Oral contraceptives.
- Prescription drugs and devices used to treat nicotine dependence, including related medical evaluations, psychotherapy, and x-ray and lab services.

See Also:

Medical and Surgical Supplies earlier in this section.

Prior Authorization, page 32.

Preventive Care

Covered:

- Mammograms.
- Pap smears. However, you are not covered for the office examination in which the Pap smear is taken if the Pap smear is for a preventive physical examination.
- Normal newborn care (physician services provided to a baby during the mother's initial hospitalization).

Service Maximum:

- Mammograms according to the following:
  - For women between the ages of 35–39: (b)(4)
  - For women between the ages of 40–49: (b)(4) (b)(4)
  - For women age 50 and older: (b)(4) (b)(4)

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

Not Covered:

- Routine foot care, including related services or supplies.
- Periodic physicals or health examinations, screening procedures, or immunizations performed solely for school, sports, employment, insurance, licensing, or travel.

- Gynecological examinations.
- Immunizations.
- Physical examinations including related services.
- Well-child care.

See Also:

Hearing Services earlier in this section.

Vision Services later in this section.

Prosthetic Devices

Covered: Devices used as artificial substitutes to replace a missing natural part of the body or to improve, aid, or increase the performance of a natural function.

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

Not Covered:

- Devices such as eyeglasses and air conduction hearing aids or examinations for their prescription or fitting.
- Elastic stockings or bandages including trusses, lumbar braces, garter belts, and similar items that can be purchased without a prescription.

See Also:

Home/Durable Medical Equipment earlier in this section.

Medical and Surgical Supplies earlier in this section.

Orthotics earlier in this section.

Personal Convenience Items in the section *General Conditions of Coverage, Exclusions, and Limitations*, page 25.

Reconstructive Surgery

Covered: Reconstructive surgery primarily intended to restore function lost or impaired as the result of an illness, injury, or a birth defect (even if there is an incidental improvement in physical appearance) including breast reconstructive surgery following mastectomy. Breast reconstructive surgery includes the following:

- Reconstruction of the breast on which the mastectomy has been performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses.
- Treatment of physical complications of the mastectomy, including lymphedemas.

See Also:

Prior Approval, page 30.

Cosmetic Services earlier in this section.

Self Help Programs

Not Covered: Self-help and self-cure products or drugs.

Sleep Apnea Treatment

Covered: Obstructive sleep apnea diagnosis and treatments.

Not Covered: Treatment for snoring without a diagnosis of obstructive sleep apnea.

Speech Therapy

Covered: Rehabilitative speech therapy treatment.

Not Covered:

- Speech therapy services not coordinated through home health services when the services are received through a home health agency.
- Speech therapy to treat certain developmental, learning, or communication disorders, such as stuttering and stammering.

See Also:

Prior Approval, page 30.

Supplemental Accidental Injury Benefit

Covered: If you are injured accidentally and are treated within 90 days of the accident, you have supplemental accidental injury benefits. **Please note:** This supplemental accidental injury benefit is applied to charges relating to an accidental injury in the order received by us. In the event that your medical benefits plan already covers such charges, the supplemental accidental injury benefit will not be available.

The supplemental accidental injury benefit only applies to:

- Hospital Services.
- Practitioner Services.
- Services of a Registered Nurse (R.N.).
- X-ray and Laboratory Services.

Service Maximum:

- (b)(4) per accident.

Not Covered:

- Dental treatment.
- Disease or infection (except pyogenic infection occurring through an accidental cut or wound).
- Services or supplies excluded by your medical benefits plan.

Surgery

Covered. This includes the following:

- Major endoscopic procedures.
- Operative and cutting procedures.
- Preoperative and postoperative care.

See Also:

Dental Services earlier in this section.

Reconstructive Surgery earlier in this section.

Temporomandibular Joint Disorder (TMD)

Covered.

Not Covered: Dental extractions, dental restorations, or orthodontic treatment for temporomandibular joint disorders.

Transplants

Not Covered: All services or supplies related to transplants, treatment, and complications, including ambulance services for transplants.

Travel or Lodging Costs

Not Covered.

Vision Services

Covered: Vision examinations but only when related to an illness or injury.

Not Covered:

- Surgery to correct a refractive error (i.e., when the shape of your eye does not bend light correctly resulting in blurred images).
- Eyeglasses or contact lenses, including charges related to their fitting.
- Eye exercises.
- Prescribing of corrective lenses.
- Eye examinations for the fitting of eyewear.
- Routine vision examinations.

Wigs or Hairpieces

Not Covered.

X-ray and Laboratory Services

Covered: Tests, screenings, imagings, and evaluation procedures as identified in the American Medical Association's Current Procedural Terminology (CPT) manual, Standard Edition, under *Radiology Guidelines* and *Pathology and Laboratory Guidelines*.

See Also:

Preventive Care earlier in this section.

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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.

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	You Pay
Deductible	
	(b)(4) per person (maximum) per family*
Office Visit Copayment	
	(b)(4) for covered services received from PPO providers.
Coinsurance	
	(b)(4) % for covered services received from PPO providers. % for covered services received from participating and nonparticipating providers.**
Lifetime Benefits Maximum	
	(b)(4) per person

*Family amounts are reached from amounts accumulated on behalf of any combination of family members.
**Participating and nonparticipating providers are non-PPO. See *Choosing a Provider*, page 27.

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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.

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

Category	Covered	Not Covered	See Page	Service Maximum
Acupuncture Treatment		⊘	11	
Allergy Testing and Treatment	●		11	
Ambulance Services	●		11	
Anesthesia	●		11	
Blood Administration	●		11	
Chemical Dependency Treatment		⊘	11	
Chemotherapy and Radiation Therapy	●		11	
Cosmetic Services		⊘	11	
Counseling Services		⊘	11	
Dental Treatment for Accidental Injury	●		11	
Dialysis	●		12	
Education Services for Diabetes		⊘	12	
Emergency Services	●		12	

Category	Covered	Not Covered	See Page	Service Maximum
Fertility Services	●		12	
Genetic Testing	●		13	
Hearing Services (related to an illness or injury)	●		13	
Home Health Services	●		13	
Home/Durable Medical Equipment	●		14	
Hospice Services	●		14	(b)(4) days per lifetime for inpatient hospice respite care. (b)(4) days per lifetime for outpatient hospice respite care. Please note: Hospice respite care must be used in increments of not more than five days at a time.
Hospitals and Facilities	●		14	
Illness or Injury Services	●		15	
Infertility Treatment		⊘	15	
Inhalation Therapy	●		15	
Maternity Services	●		15	
Medical and Surgical Supplies	●		16	
Mental Health Services		⊘	16	
Morbid Obesity Treatment	●		16	
Motor Vehicles		⊘	16	
Musculoskeletal Treatment	●		16	
Nonmedical Services		⊘	16	
Occupational Therapy	●		16	
Orthotics		⊘	17	
Over-the-Counter Products		⊘	17	
Physical Therapy	●		17	
Physicians and Practitioners			17	
Advanced Registered Nurse Practitioners	●		17	
Audiologists	●		17	
Chiropractors	●		17	
Doctors of Osteopathy	●		17	
Licensed Independent Social Workers	●		17	
Licensed Marriage and Family Therapists.		⊘	17	
Licensed Mental Health Counselors		⊘	17	
Medical Doctors	●		17	
Occupational Therapists	●		17	
Optometrists	●		17	
Oral Surgeons	●		17	
Physical Therapists	●		17	
Physician Assistants	●		17	

Category	Covered	Not Covered	See Page	Service Maximum
Podiatrists	●		17	
Psychologists	●		17	
Speech Pathologists	●		17	
Prescription Drugs	●		17	
Preventive Care	●		18	Mammograms according to the following schedule unless recommended more frequently by your physician: ■ For women 35-39 years of age: (b)(4) (b)(4) ■ For women 40-49 years of age: (b)(4) (b)(4) ■ 50 years of age and older: (b)(4) (b)(4)
Prosthetic Devices	●		19	
Reconstructive Surgery	●		19	
Self Help Programs		⊘	19	
Sleep Apnea Treatment	●		19	
Speech Therapy	●		19	
Supplemental Accidental Injury Benefit	●		20	
				(b)(4) per accident.
Surgery	●		20	
Temporomandibular Joint Disorder (TMD)	●		20	
Transplants		⊘	20	
Travel or Lodging Costs		⊘	20	
Vision Services (related to an illness or injury)	●		20	
Wigs or Hairpieces		⊘	20	
X-ray and Laboratory Services	●		20	

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

Acupuncture Treatment

Not Covered: Acupuncture and acupressure treatment.

Allergy Testing and Treatment

Covered.

Ambulance Services

Covered: Professional air and ground ambulance transportation to a hospital or nursing facility in the surrounding area where your ambulance transportation originates.

All of the following are required to qualify for benefits:

- No other method of transportation is appropriate.
- The services required to treat your illness or injury are not available in the facility where you are currently receiving care if you are an inpatient at a facility.
- You are transported to the nearest hospital or nursing facility with adequate facilities to treat your medical condition.

See Also:

Transplants later in this section.

Anesthesia

Covered: Anesthesia and the administration of anesthesia.

Not Covered: Local or topical anesthesia billed separately from related surgical or medical procedures.

Blood Administration

Covered: Blood administration.

Not Covered: Blood. This exclusion does not apply to members with hemophilia.

Chemical Dependency Treatment

Not Covered.

Chemotherapy and Radiation Therapy

Covered: Use of chemical agents or radiation to treat or control a serious illness.

Cosmetic Services

Not Covered: Cosmetic services, supplies, or drugs unless provided primarily to restore function lost or impaired as the result of an illness, accidental injury, or a birth defect including treatment for any complications resulting from a noncovered cosmetic procedure.

See Also:

Reconstructive Surgery later in this section.

Counseling Services

Not Covered: Bereavement counseling or services (including volunteers or clergy), family counseling or training services, and marriage counseling or training services.

See Also:

Genetic Testing later in this section.

Dental Services

Covered:

- Dental treatment for accidental injuries when:

  - Treatment is completed within six months of the injury.
- Anesthesia (general) and hospital or ambulatory surgical facility services related to covered dental services if:
  - You are under age 14 and, based on a determination by a licensed dentist and your treating physician, you have a dental or developmental condition for which patient management in the dental office has been ineffective and requires dental treatment in a hospital or ambulatory surgical facility; or
  - Based on a determination by a licensed dentist and your treating physician, you have one or more medical conditions that would create significant or undue medical risk in the course of delivery of any necessary dental treatment or surgery if not rendered in a hospital or ambulatory surgical facility.
- Impacted teeth removal (surgical) as an inpatient or outpatient of a facility only when you have a medical condition (such as hemophilia) that requires hospitalization.
- Facial bone fracture reduction.
- Incisions of accessory sinus, mouth, salivary glands, or ducts.
- Jaw dislocation manipulation.
- Treatment of abnormal changes in the mouth due to injury or disease.

Not Covered:

- General dentistry including, but not limited to, diagnostic and preventive services, restorative services, endodontic services, periodontal services, indirect fabrications, dentures and bridges, and orthodontic services.
- Injuries associated with or resulting from the act of chewing.
- Maxillary or mandibular tooth implants (osseointegration).

Dialysis

Covered: Removal of toxic substances from the blood when the kidneys are unable to do so when provided as an inpatient in a hospital setting or as an outpatient in a Medicare-approved dialysis center.

Education Services for Diabetes

Not Covered: Diabetes education programs.

Emergency Services

Covered: When treatment is for a medical condition manifested by acute symptoms of sufficient severity, including pain, that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect absence of immediate medical attention to result in:

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

In an emergency situation, if you cannot reasonably reach a PPO provider, covered services will be reimbursed as though they were received from a PPO provider. However, because we do not have contracts with nonparticipating providers and they may not accept our payment arrangements, you are responsible for any difference between the amount charged and our amount paid for a covered service.

See Also:

Nonparticipating providers, page 36.

Fertility Services

Covered:

- Fertility prevention, such as tubal ligation (or its equivalent) or vasectomy (initial surgery only).

Genetic Testing

Covered: Genetic molecular testing (specific gene identification) and related counseling are covered when both of the following requirements are met:

- You are an appropriate candidate for a test under medically recognized standards (for example, family background, past diagnosis, etc.).
- The outcome of the test is expected to determine a covered course of treatment or prevention and is not merely informational.

See Also:

Prior Approval, page 30.

Hearing Services

Covered:

- Hearing examinations, but only to test or treat hearing loss related to an illness or injury.

Not Covered:

- Hearing aids.
- Routine hearing examinations.

Home Health Services

Covered: All of the following requirements must be met in order for home health services to be covered:

- You require a medically necessary skilled service such as skilled nursing, physical therapy, or speech therapy.
- Services are received from an agency accredited by the Joint Commission for Accreditation of Health Care Organizations (JCAHO) and/or a Medicare-certified agency.
- Services are prescribed by a physician and approved by our case manager for the treatment of illness or injury.
- Services are not more costly than alternative services that would be effective for diagnosis and treatment of your condition.
- The care is prescribed by a physician and approved by a Wellmark case manager.

The following are covered services and supplies:

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

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

Inhalation Therapy.

Medical Equipment.

Medical Social Services.

Medical Supplies.

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

Oxygen and Equipment for its administration.

Parenteral and Enteral Nutrition.

Physical Therapy.

Prescription Drugs and Medicines administered in the vein or muscle.

Prosthetic Devices and Braces.

Speech Therapy.

Not Covered: Custodial home care services and supplies, which help you with your daily living activities. This type of care does not require the continuing attention and assistance of licensed medical or trained paramedical personnel. Some examples of custodial care are assistance in walking and getting in and out of bed; aid in bathing, dressing, feeding, and other forms of assistance with normal bodily functions; preparation of special diets; and supervision of medication that can usually be self-administered. You are also not covered for sanitaria care or rest cures.

See Also:

Case Management, page 31.

Precertification, page 29.

Home/Durable Medical Equipment

Covered: Equipment that meets all of the following requirements:

- Durable enough to withstand repeated use.
- Primarily and customarily manufactured to serve a medical purpose.
- Used to serve a medical purpose.

In addition, we determine whether to pay the rental amount or the purchase price amount for an item, and we determine the length of any rental term. Benefits will never exceed the lesser of the amount charged or the maximum allowable fee.

See Also:

Medical and Surgical Supplies later in this section.

Orthotics later in this section.

Personal Convenience Items in the section *General Conditions of Coverage, Exclusions, and Limitations*, page 25.

Prosthetic Devices later in this section.

Prior Approval, page 30.

Hospice Services

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

Hospice respite care offers rest and relief help for the family caring for a terminally ill patient. Inpatient respite care can take place in a nursing home, nursing facility, or hospital. Hospice care must be precertified.

Service Maximum:

- (b)(4) **days** per lifetime for inpatient pice respite care.
- (b)(4) **days** per lifetime for outpatient spice respite care.
- Not more than (b)(4) **days** of hospice respite care at a time.

See Also:

Precertification, page 29.

Hospitals and Facilities

Covered: Hospitals and other facilities that meet standards of licensing, accreditation or certification. Following are some recognized facilities:

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

Hospital. This type of facility provides for the diagnosis, treatment, or care of injured or sick persons on an inpatient and outpatient basis. The facility must

be licensed as a hospital under applicable law.

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

Illness or Injury Services

Covered: Services or supplies used to treat any bodily disorder, bodily injury, disease, or mental health condition unless specifically addressed elsewhere in this section. This includes pregnancy and complications of pregnancy.

Treatment may be received from an approved provider in any of the following settings:

- Home.
- Inpatient (such as a hospital or nursing facility).
- Office (such as a doctor's office).
- Outpatient.

See Also:

Precertification, page 29.

Infertility Treatment

Not Covered:

- Infertility treatment if the infertility is the result of voluntary sterilization.
- Infertility treatment related to the collection or purchase of donor semen (sperm) or oocytes (eggs); freezing of sperm, oocytes, or embryos; surrogate parent services.
- Infertility diagnosis and treatment.
- Reversal of a tubal ligation (or its equivalent) or vasectomy.

Inhalation Therapy

Covered: Respiratory or breathing treatments to help restore or improve breathing function.

Maternity Services

Covered: Prenatal and postnatal care, delivery, including complications of pregnancy. A complication of pregnancy refers to a cesarean section that was not planned, an ectopic pregnancy that is terminated, or a spontaneous termination of pregnancy that occurs during a period of gestation in which a viable birth is not possible. Complications of pregnancy also include conditions requiring inpatient hospital admission (when pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy.

In accordance with federal or applicable state law, maternity services include a minimum of:

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

A practitioner is not required to seek Wellmark's review in order to prescribe a length of stay of less than 48 or 96 hours. The attending practitioner, in consultation with the mother, may discharge the mother or newborn prior to 48 or 96 hours, as applicable.

If the inpatient hospital stay is shorter, coverage includes a follow-up postpartum home visit by a registered nurse (R.N.). This nurse must be from a home health agency under contract with Wellmark or employed by the delivering physician.

See Also:

Coverage Change Events, page 43.

Medical and Surgical Supplies

Covered: Medical supplies and devices such as:

- Dressings and casts.
- Oxygen and equipment needed to administer the oxygen.
- Insulin syringes and supplies.

Not Covered:

- Elastic stockings or bandages including trusses, lumbar braces, garter belts, and similar items that can be purchased without a prescription.

See Also:

Home/Durable Medical Equipment earlier in this section.

Orthotics later in this section.

Prescription Drugs later in this section.

Personal Convenience Items in the section *General Conditions of Coverage, Exclusions, and Limitations*, page 25.

Prosthetic Devices later in this section.

Mental Health Services

Not Covered.

Morbid Obesity Treatment

Covered: Weight reduction surgery provided you meet eligibility criteria for age and medical condition and history. Not all procedures classified as weight reduction surgery are covered. Prior approval for weight reduction surgery is strongly recommended. For information on how to submit a prior approval request, refer to *Prior Approval* in the *Notification Requirements and Care Coordination* section of this coverage manual, or call the Customer Service number on your ID card. For the criteria we use to determine prior approval, you may call the Customer Service number on your ID card or visit our Web site at *www.wellmark.com*.

Not Covered:

- Weight reduction programs or supplies (including dietary supplements, foods, equipment, lab testing, examinations, and prescription drugs), whether or not weight reduction is medically appropriate.

See Also:

Prior Approval, page 30.

Motor Vehicles

Not Covered: Purchase or rental of motor vehicles such as cars or vans. You are also not covered for equipment or costs associated with converting a motor vehicle to accommodate a disability.

Musculoskeletal Treatment

Covered: Outpatient nonsurgical treatment of ailments related to the musculoskeletal system, such as manipulations or related procedures to treat musculoskeletal injury or disease.

Not Covered: Massage therapy.

Nonmedical Services

Not Covered: Such services as telephone consultations, charges for failure to keep scheduled appointments, charges for completion of any form, charges for medical information, and educational or recreational therapy or services or supplies that are nonmedical.

Occupational Therapy

Covered: Services are covered, but only those services to treat the upper extremities, which means the arms from the shoulders to the fingers.

Not Covered:

- Occupational therapy supplies.
- Occupational therapy provided as an inpatient in the absence of a separate medical condition that requires hospitalization.

Orthotics

Not Covered: Orthotic foot devices such as arch supports or in-shoe supports, orthopedic shoes, elastic supports, or examinations to prescribe or fit such devices.

See Also:

Home/Durable Medical Equipment earlier in this section.

Personal Convenience Items in the section *General Conditions of Coverage, Exclusions, and Limitations*, page 25.

Prosthetic Devices later in this section.

Over-the-Counter Products

Not Covered: Most over-the-counter products, including nutritional dietary supplements. However, certain over-the-counter products prescribed by a physician may be covered. To determine if a particular over-the-counter product is covered, call the Customer Service number on your ID card.

Physical Therapy

Covered.

Not Covered: Physical therapy provided as an inpatient in the absence of a separate medical condition that requires hospitalization.

Physicians and Practitioners

Covered: Most services provided by practitioners that are recognized by us and meet standards of licensing, accreditation or certification. Following are some recognized physicians and practitioners:

Advanced Registered Nurse Practitioners (ARNP). An ARNP is a registered nurse with advanced training in a specialty area who is registered with the Iowa Board of Nursing to practice in an advanced role with a specialty designation of certified clinical nurse specialist, certified nurse midwife, certified nurse practitioner, or certified registered nurse anesthetist.

Audiologists.

Chiropractors.

Doctors of Osteopathy (D.O.).

Licensed Independent Social Workers.

Medical Doctors (M.D.).

Occupational Therapists. This provider is covered only when treating the upper extremities, which means the arms from the shoulders to the fingers.

Optometrists.

Oral Surgeons.

Physical Therapists.

Physician Assistants.

Podiatrists.

Psychologists. Psychologists must have a doctorate degree in psychology with two years' clinical experience and meet the standards of a national register.

Speech Pathologists.

Not Covered:

- Athletic Trainers.
- Licensed Marriage and Family Therapists.
- Licensed Mental Health Counselors.

See Also:

Choosing a Provider, page 27.

Prescription Drugs

Covered:

- Prescription drugs and medicines received as an inpatient or outpatient of a facility.

A prescription drug is one that bears the legend, "Caution, Federal Law prohibits dispensing without a prescription."

Additional prescription drugs and medicines covered under this medical benefits plan include:

Drugs and Biologicals. Drugs and biologicals approved by the Food and Drug Administration. This includes such supplies as globulin, serum, vaccine, antitoxin, or antigen used in the prevention or treatment of disease.

Insulin.

Intravenous Administration. Intravenous administration of nutrients, antibiotics, and other drugs and fluids when provided in the home (home infusion therapy).

Self-Administered Injectable Drugs. Self-administered injectable drugs are generally covered under this medical benefits plan.

Not Covered:

- Prescriptions purchased from a retail pharmacy.

  Please note: Although your plan does not include benefits for prescription drugs at a pharmacy, you may save money when you use your ID card to fill prescriptions under your plan. Even though you must pay in full for any otherwise eligible prescription drug, the amount you pay at a participating pharmacy under this plan is the maximum allowable fee, which may be less than the charged amount that you would pay in the absence of your coverage. See Maximum Allowable Fee, in the Factors Affecting What You Pay section.
- Drugs purchased outside the United States.
- Contraceptive devices.
- Contraceptives absorbed through the skin.
- Implanted contraceptives.
- Injected contraceptives.
- Oral contraceptives.
- Prescription drugs and devices used to treat nicotine dependence, including related medical evaluations, psychotherapy, and x-ray and lab services.

See Also:

Medical and Surgical Supplies earlier in this section.

Prior Authorization, page 32.

Preventive Care

Covered:

- Mammograms.
- Pap smears. However, you are not covered for the office examination in which the Pap smear is taken if the Pap smear is for a preventive physical examination.
- Normal newborn care (physician services provided to a baby during the mother's initial hospitalization).

Service Maximum:

- Mammograms according to the following:
  - For women between the ages of 35–39: (b)(4)
  - For women between the ages of 40–49: (b)(4) (b)(4)
  - For women age 50 and older: (b)(4) (b)(4)

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

Not Covered:

- Routine foot care, including related services or supplies.
- Periodic physicals or health examinations, screening procedures, or immunizations performed solely for school, sports, employment, insurance, licensing, or travel.

- Gynecological examinations.
- Immunizations.
- Physical examinations including related services.
- Well-child care.

See Also:

Hearing Services earlier in this section.

Vision Services later in this section.

Prosthetic Devices

Covered: Devices used as artificial substitutes to replace a missing natural part of the body or to improve, aid, or increase the performance of a natural function.

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

Not Covered:

- Devices such as eyeglasses and air conduction hearing aids or examinations for their prescription or fitting.
- Elastic stockings or bandages including trusses, lumbar braces, garter belts, and similar items that can be purchased without a prescription.

See Also:

Home/Durable Medical Equipment earlier in this section.

Medical and Surgical Supplies earlier in this section.

Orthotics earlier in this section.

Personal Convenience Items in the section *General Conditions of Coverage, Exclusions, and Limitations*, page 25.

Reconstructive Surgery

Covered: Reconstructive surgery primarily intended to restore function lost or impaired as the result of an illness, injury, or a birth defect (even if there is an incidental improvement in physical appearance) including breast reconstructive surgery following mastectomy. Breast reconstructive surgery includes the following:

- Reconstruction of the breast on which the mastectomy has been performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses.
- Treatment of physical complications of the mastectomy, including lymphedemas.

See Also:

Prior Approval, page 30.

Cosmetic Services earlier in this section.

Self Help Programs

Not Covered: Self-help and self-cure products or drugs.

Sleep Apnea Treatment

Covered: Obstructive sleep apnea diagnosis and treatments.

Not Covered: Treatment for snoring without a diagnosis of obstructive sleep apnea.

Speech Therapy

Covered: Rehabilitative speech therapy treatment.

Not Covered:

- Speech therapy services not coordinated through home health services when the services are received through a home health agency.
- Speech therapy to treat certain developmental, learning, or communication disorders, such as stuttering and stammering.

See Also:

Prior Approval, page 30.

Supplemental Accidental Injury Benefit

Covered: If you are injured accidentally and are treated within 90 days of the accident, you have supplemental accidental injury benefits. **Please note:** This supplemental accidental injury benefit is applied to charges relating to an accidental injury in the order received by us. In the event that your medical benefits plan already covers such charges, the supplemental accidental injury benefit will not be available.

The supplemental accidental injury benefit only applies to:

- Hospital Services.
- Practitioner Services.
- Services of a Registered Nurse (R.N.).
- X-ray and Laboratory Services.

Service Maximum:

- (b)(4) per accident.

Not Covered:

- Dental treatment.
- Disease or infection (except pyogenic infection occurring through an accidental cut or wound).
- Services or supplies excluded by your medical benefits plan.

Surgery

Covered. This includes the following:

- Major endoscopic procedures.
- Operative and cutting procedures.
- Preoperative and postoperative care.

See Also:

Dental Services earlier in this section.

Reconstructive Surgery earlier in this section.

Temporomandibular Joint Disorder (TMD)

Covered.

Not Covered: Dental extractions, dental restorations, or orthodontic treatment for temporomandibular joint disorders.

Transplants

Not Covered: All services or supplies related to transplants, treatment, and complications, including ambulance services for transplants.

Travel or Lodging Costs

Not Covered.

Vision Services

Covered: Vision examinations but only when related to an illness or injury.

Not Covered:

- Surgery to correct a refractive error (i.e., when the shape of your eye does not bend light correctly resulting in blurred images).
- Eyeglasses or contact lenses, including charges related to their fitting.
- Eye exercises.
- Prescribing of corrective lenses.
- Eye examinations for the fitting of eyewear.
- Routine vision examinations.

Wigs or Hairpieces

Not Covered.

X-ray and Laboratory Services

Covered: Tests, screenings, imagings, and evaluation procedures as identified in the American Medical Association's Current Procedural Terminology (CPT) manual, Standard Edition, under *Radiology Guidelines* and *Pathology and Laboratory Guidelines*.

See Also:

Preventive Care earlier in this section.

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Benefit *Summary*

Alliance Select Health Plan
CRST International Inc. - Medical Bridge Plan
Customer Service Phone Hours are 7:30 a.m. to 5:00 p.m. CST
Call 1-800-600-4149

This is a general description of coverage. It is not a statement of contract. Actual coverage is subject to terms and conditions specified in the Coverage Manual you will receive after you enroll and the enrollment regulations in force when the certificate becomes effective. Certain exclusions and limitations apply.

Health Plan Basics **You can receive care from any provider you choose. When you choose a provider who participates in the Alliance Select network, you reduce your out-of-pocket expenses. Refer to the Alliance Select provider directory for a complete list of Alliance Select providers.**	
Lifetime Benefits Maximum - The maximum amount each covered family member is eligible to receive under this plan for covered services in his or her lifetime.	$ (b)(4)
Out-of Pocket Expenses - The amount you pay for certain covered services. There are three types of out-of-pocket expenses: 1) Copayment - a specific amount you pay at the time you receive scheduled services. 2) Deductible - a fixed amount you pay for certain services before Wellmark makes benefit payments. 3) Coinsurance - a fixed percentage you pay for certain services	See the next page for your specific out-of-pocket amounts.
Benefit Period Deductible	Single: (b)(4) Family:
Coverage for Care Provided Outside of Iowa	BlueCard® PPO Program benefits apply.

See reverse side for more information about your Alliance Select health plan.

When You Receive These Covered Services:	You Pay:	
	Select Providers	**Non-Select Providers**
Office Visit Services	(b)(4) copayment; *Deductible waived*	(b)(4)% coinsurance after deductible
Inpatient Physician Services	(b)(4)% coinsurance after deductible	(b)(4)% coinsurance after deductible
Inpatient Hospital Services	(b)(4)% coinsurance after deductible	(b)(4)% coinsurance after deductible
Outpatient Physician Services	(b)(4)% coinsurance after deductible	(b)(4)% coinsurance after deductible
Outpatient Hospital Services	(b)(4)% coinsurance after deductible	(b)(4)% coinsurance after deductible
Emergency Services ** **Physician's office** **Emergency room**	 (b)(4) copayment *Deductible waived* (b)(4)% coinsurance after deductible	 (b)(4)% coinsurance after deductible (b)(4)% coinsurance after deductible
Chiropractic Care	(b)(4) copayment *Deductible waived*	(b)(4) coinsurance after deductible
Maternity Care Inpatient/Outpatient	(b)(4) coinsurance after deductible	(b)(4) coinsurance after deductible
Prescription Drugs	(b)(4) of the allowed amount	

**** Processed at in-network level if true emergency.**

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From: Scelzo, Kathleen (HHS/OCIIO)
Sent: Thursday, November 04, 2010 11:56 AM
To: 'bwilley@crst.com'
Cc: Habit, Sandra (HHS/OCIIO)
Subject: CRST Internation Waiver Application

Attachments: CRST International Waiver Application Questions.doc

Brooke Willey,

I left you a message yesterday about CRST Internation application for Annual Limits Requirements of the PHS Act Section 2711. Attached above is the document that needs to be completed in order to finalize the application process.

Many thanks for your assistance with this document.

Kathleen M. Scelzo, RN, MSN
Rules Compliance Division
Office of Insurance Oversight
Office of Consumer Information and Insurance Oversight (OCIIO)
Department of Health and Human Services
7501 Wisconsin Avenue
Bethesda, MD
301-492-4121

November 4, 2010

Dear Applicant:

RE: CRST International:

Thank you for your application for the Waiver of the Annual Limits Requirements of the PHS Act Section 2711. In order to complete your application, please provide the following information about the CRST International Plan:

1. Effective date of policy.

2. (The premium amounts is the total cost to the employer and the employee)

	Premium (current level)	Premium (renewal)	Premium (if $750,000 annual limit was applied)	% increase if the $750,000 was implemented
EE				
EE + Child (if applicable or other appropriate tier)				
EE + Spouse (if applicable or other appropriate tier)				
Family (if applicable or other appropriate tier)				

3. Indicate if the plan is fully-insured plan or a self-insured plan.

4. Type of Plan:

☐ Limited Benefit	☐ Prescription	☐ HRA
☐ Comprehensive	☐ Other	

Please provide this information by 5:00 pm, Monday November 8, 2010. We look forward to receiving your completed application. Thank you.

Sincerely,

Kathleen M. Scelzo, RN, MSN
Rules Compliance Division
Office of Insurance Oversight
Office of Consumer Information and Insurance Oversight (OCIIO)
Department of Health and Human Services
301-492-4121

From: BWilley@crst.com
Sent: Thursday, November 04, 2010 7:09 PM
To: Scelzo, Kathleen (HHS/OCIIO)
Cc: Habit, Sandra (HHS/OCIIO)
Subject: Re: CRST Internation Waiver Application

Attachments: CRST International Waiver Application Questions.doc; CRST International Waiver Application Questions.doc

Kathleen -
Attached please find the completed application, per your email.
Should you have any questions, please feel free to contact me at the number listed below.
Kind regards,

Brooke Willey, VP - Human Resources
CRST International, Cedar Rapids, IA
direct: 319/390-2856 cell: (b)(6)

From:	"Scelzo, Kathleen (HHS/OCIIO)" <Kathleen.Scelzo@hhs.gov>
To:	"'bwilley@crst.com'" <bwilley@crst.com>
Cc:	"Habit, Sandra (HHS/OCIIO)" <Sandra.Habit@hhs.gov>
Date:	11/04/2010 10:56 AM
Subject:	CRST Internation Waiver Application

Brooke Willey,
I left you a message yesterday about CRST Internation application for Annual Limits Requirements of the PHS Act Section 2711. Attached above is the document that needs to be completed in order to finalize the application process.

Many thanks for your assistance with this document.

Kathleen M. Scelzo, RN, MSN
Rules Compliance Division
Office of Insurance Oversight
Office of Consumer Information and Insurance Oversight (OCIIO)
Department of Health and Human Services
7501 Wisconsin Avenue
Bethesda, MD
301-492-4121

November 4, 2010

Dear Applicant:

RE: CRST International:

Thank you for your application for the Waiver of the Annual Limits Requirements of the PHS Act Section 2711. In order to complete your application, please provide the following information about the CRST International Plan:

1. Effective date of policy.

2. (The premium amounts is the total cost to the employer and the employee)

	Premium (current level)	Premium (renewal)	Premium (if $750,000 annual limit was applied)	% increase if the $750,000 was implemented
EE				
EE + Child (if applicable or other appropriate tier)				
EE + Spouse (if applicable or other appropriate tier)				
Family (if applicable or other appropriate tier)				

3. Indicate if the plan is fully-insured plan or a self-insured plan.

4. Type of Plan:

☐ Limited Benefit	☐ Prescription	☐ HRA
☐ Comprehensive	☐ Other	

Please provide this information by 5:00 pm, Monday November 8, 2010. We look forward to receiving your completed application. Thank you.

Sincerely,

Kathleen M. Scelzo, RN, MSN
Rules Compliance Division
Office of Insurance Oversight
Office of Consumer Information and Insurance Oversight (OCIIO)
Department of Health and Human Services
301-492-4121

November 4, 2010

Dear Applicant:

RE: CRST International:

Thank you for your application for the Waiver of the Annual Limits Requirements of the PHS Act Section 2711. In order to complete your application, please provide the following information about the CRST International Plan:

1. Effective date of policy. **The policy is a calendar year policy and is in effect on January 1 of each calendar year, since inception of 1/1/02.**

2. (The premium amounts is the total cost to the employer and the employee)

	Premium (current level)	Premium (renewal)	Premium (if $750,000 annual limit was applied)	% increase if the $750,000 was implemented
EE	(b)(4)			
EE + Child (if applicable or other appropriate tier)	NA	NA	NA	NA
EE + Spouse (if applicable or other appropriate tier)	NA	NA	NA	NA
Family (if applicable or other appropriate tier)	(b)(4)			

3. Indicate if the plan is fully-insured plan or a self-insured plan. **The plan is self insured.**

4. Type of Plan:

x Limited Benefit	x Prescription (discounts)	☐ HRA
☐ Comprehensive	☐ Other	

Please provide this information by 5:00 pm, Monday November 8, 2010. We look forward to receiving your completed application. Thank you.

Sincerely,

Kathleen M. Scelzo, RN, MSN
Rules Compliance Division
Office of Insurance Oversight
Office of Consumer Information and Insurance Oversight (OCIIO)
Department of Health and Human Services
301-492-4121

From: Botwinick, Alexandra (HHS/OCIIO)
Sent: Monday, November 15, 2010 9:48 AM
To: 'bwilley@crst.com'
Subject: Waiver of the Annual Limits Requirements of PHS Act Section 2711

Importance: High

Attachments: Updated Jan 1 Approval Letter .pdf
Good Morning,

Thank you for submitting an application for a Waiver of the Annual Limits Requirements of the PHS Act Section for CRST International. HHS has reviewed your application and made its determination. Please see the attached letter.

Please confirm receipt of this letter by replying to this e-mail address with a copy to OCIIOOversight@hhs.gov.

Please let me know if I can be of further assistance.

Sincerely,

Alexandra Botwinick

Office of Oversight
HHS/OCIIO
alexandra.botwinick@hhs.gov

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Consumer Information and
Insurance Oversight
Washington, DC 20201

Date: October 2010

From: Steve Larsen, Director, Office of Oversight

Subject: Application for Waiver of the Annual Limits Requirements of PHS Act Section 2711

Dear Waiver Applicant:

Section 2711(a)(2) of the Public Health Service Act (PHS Act), as added by the Patient Protection and Affordable Care Act (Affordable Care Act), requires the Secretary to impose restrictions on the imposition of annual limits on the dollar value of essential health benefits (as defined in section 1302(b) of the Affordable Care Act) for any participant or beneficiary in a new or existing group health plan or a new policy in the individual market for plan or policy years beginning on or after September 23, 2010 and prior to January 1, 2014. Specifically, the Secretary is granted the authority to determine what constitutes a "restricted annual limit" that can still be imposed under such plans or policies prior to January 1, 2014.

The interim final regulations published on June 28, 2010 (codified at 26 CFR § 54.9815-2719T; 29 CFR § 2590.715-2719; and 45 CFR §147.126) established such restricted annual limits. The regulations also provided that these restricted annual limits may be waived by the Secretary of Health and Human Services (HHS) if compliance with the interim final regulations would result in a significant decrease in access to benefits or a significant increase in premiums. Pursuant to the regulation, HHS issued guidance on September 3 regarding the scope and process for applying for a waiver.

The Office of Consumer Information and Insurance Oversight, Office of Insurance Oversight received and processed your application for the plan(s) or policy(ies) year beginning January 1, 2011. We have determined that your application has met the criteria to obtain a waiver of the restricted annual limits requirements because compliance with the interim final regulations would result in a significant decrease in access to benefits for those currently covered by such plans or policies, or a significant increase in premiums paid by those covered by such plans or policies. To the extent you make any change to your benefit package after March 23, 2010, you must determine whether the change(s) will trigger loss of grandfathering status pursuant to 45 CFR §147.140(g)(1).

An approval of your request for waiver of the restricted annual limits requirements granted under this process applies only to the annual limit(s) provided in your application for the plan or policy year beginning between September 23, 2010 and September 23, 2011. This waiver only applies to the annual limits requirements in Section 2711 of the ACA and does not apply to any other requirement of the Affordable Care Act, ERISA, the IRS Code or the PHS Act. Further, a group

health plan or health insurance issuer must reapply for any subsequent plan or policy year prior to January 1, 2014 when this waiver expires in accordance with future guidance from HHS. HHS may modify this waiver approval process memorandum and other relevant information.

If you have any questions regarding this letter, please email OCIIOOversight@hhs.gov.

From: BWilley@crst.com
Sent: Monday, November 15, 2010 10:03 AM
To: Botwinick, Alexandra (HHS/OCIIO)
Cc: OCIIO Oversight
Subject: Re: Waiver of the Annual Limits Requirements of PHS Act Section 2711

Alexandra -
This email confirms receipt of this correspondence.
Kind regards,
Brooke

Brooke Willey, VP - Human Resources
CRST International, Inc.
3930 16th Ave SW
Cedar Rapids, IA 52406
direct: 319/390-2856
bwilley@crst.com
www.crst.com

From:	"Botwinick, Alexandra (HHS/OCIIO)" <Alexandra.Botwinick@hhs.gov>
To:	"'bwilley@crst.com'" <bwilley@crst.com>
Date:	11/15/2010 08:48 AM
Subject:	Waiver of the Annual Limits Requirements of PHS Act Section 2711

Good Morning,

Thank you for submitting an application for a Waiver of the Annual Limits Requirements of the PHS Act Section for CRST International. HHS has reviewed your application and made its determination. Please see the attached letter.

Please confirm receipt of this letter by replying to this e-mail address with a copy to OCIIOOversight@hhs.gov.

Please let me know if I can be of further assistance.

Sincerely,

Alexandra Botwinick

Office of Oversight
HHS/OCIIO

alexandra.botwinick@hhs.gov

[attachment "Updated Jan 1 Approval Letter .pdf" deleted by Brooke Willey/crst_inc]