2009 Insurance Program

RR Donnelley

M-51850 12/08

RR Donnelley Retiree Insurance Program

As you begin your retirement, you'll undoubtedly start thinking about how you'll spend all of your free time. Maybe you'll visit the grandkids, hit the golf course, or start the career you've always dreamed of. Whatever you do, you can do it with peace of mind knowing that you won't have to worry about your health insurance coverage.

Through this insurance program, you have access to health insurance coverage from a name you know and trust — Wellmark Blue Cross and Blue Shield of Iowa. For decades, Wellmark has provided quality health insurance to the people of Iowa. That's why more than 1.7 million* Iowans rely on The Blues® for their health insurance coverage.

WITH HEALTH INSURANCE COVERAGE FROM WELLMARK, YOU'LL RECEIVE:

- **Stability and confidence** — Wellmark Blue Cross and Blue Shield of Iowa is known for financial strength and stability. With over 70 years of experience, you can trust that we'll be here for you in the future.
- **Personal customer service** — Wellmark is a local company focused on providing its customers with quality products and services. You can count on friendly and courteous customer service representatives who are professionally trained to understand your Medicare benefits, accurately and efficiently answer your questions, and discuss your concerns.
- **Worldwide acceptance** — No matter where you go, you can trust that your Wellmark coverage will be accepted anywhere in the world.

You are encouraged to read all of the information you receive regarding your health insurance coverage, including this brochure. If you have questions about your group's retiree insurance program, please call a customer service representative at 1-800-245-6106.

WE LOOK FORWARD TO SERVING YOU.

**Wellmark Actuarial Services, June 2008*

What is Medicare?

Medicare is a federal health insurance program for people age 65 or older, people under age 65 with certain disabilities, or people of any age with permanent kidney failure. Medicare is administered by The Center for Medicare and Medicaid Services (CMS) of the United States Department of Health and Human Services.

There are two parts to Original Medicare:

Medicare Part A is hospital insurance that helps pay for inpatient care in hospitals and skilled nursing facilities. It is available to most Medicare-eligible beneficiaries at no cost.

Medicare Part B is medical insurance that helps pay for doctor visits, physician services, specialists, durable medical equipment, and outpatient hospital treatment. Part B is available to most Medicare-eligible beneficiaries for a monthly premium.

Original Medicare does not cover all medical costs. The deductibles, copayments, and coinsurance you must pay before Medicare covers health care costs, can quickly add up. Fortunately, people can enroll in private health plan options, like the retiree insurance program, to help cover the costs that Original Medicare does not cover.

Why do I need health insurance to complement Medicare?

Medicare provides basic protection against the high cost of health care, but it will not pay for all of your medical expenses. That's why your employer is offering you the option to enroll in this Wellmark Blue Cross and Blue Shield coverage in conjunction with Medicare. Your retiree plan is designed to provide additional coverage to help you pay for some hospital, medical and surgical services that are only partially covered by Medicare.

How does the retiree insurance program work with Medicare?

Medicare will pay your covered expenses first, and then your retiree insurance program will provide coverage for the remaining eligible expenses. Please see the itemized chart on the following pages for a more detailed explanation of the benefits.

How are the claims handled?

In most cases, your health care provider will file your Medicare claims for you, even if they are a non-participating provider. However, there may be some cases where you have to file claims yourself.

Wellmark Blue Cross and Blue Shield of Iowa will process your claim for your retiree insurance program benefits promptly and accurately when we receive and Explanation of Medicare Benefits (EOMB) from the Medicare office serving the state where the services were provided. How that EOMB gets to us depends on where you received the services.

Iowa Providers

Wellmark Blue Cross and Blue Shield of Iowa has a "cross-over" contract with many Medicare carriers and intermediaries, which means you will not have to file your claims because Medicare automatically sends it directly to us. When you doctor, clinic, hospital, or other provider is in the state of Iowa, you do not have to do anything. The Medicare office in Iowa sends your claim directly to Wellmark.

Providers outside of Iowa

If you receive health care services when you are in another state, the provider will submit your Medicare claim to the Medicare office in that state. Some out-of-state Medicare offices do not transfer the claim to us. Once a claim is processed by a Medicare office in another state, you will receive a Medicare Summary Notice (MSN). You need to send us your MSN so we can process your retiree insurance program benefits. You can send the MSN to:

Wellmark Blue Cross and Blue Shield of Iowa
Station 39
636 Grand Avenue
Des Moines, Iowa 50309-2565

Online Member Resources

In addition to offering excellent customer service through our specialized Medicare representatives, Wellmark also provides valuable resources online to take the hassle and worry out of health coverage. Visit www.wellmark.com to learn more about benefits and other health-related issues.

Informational Web Site

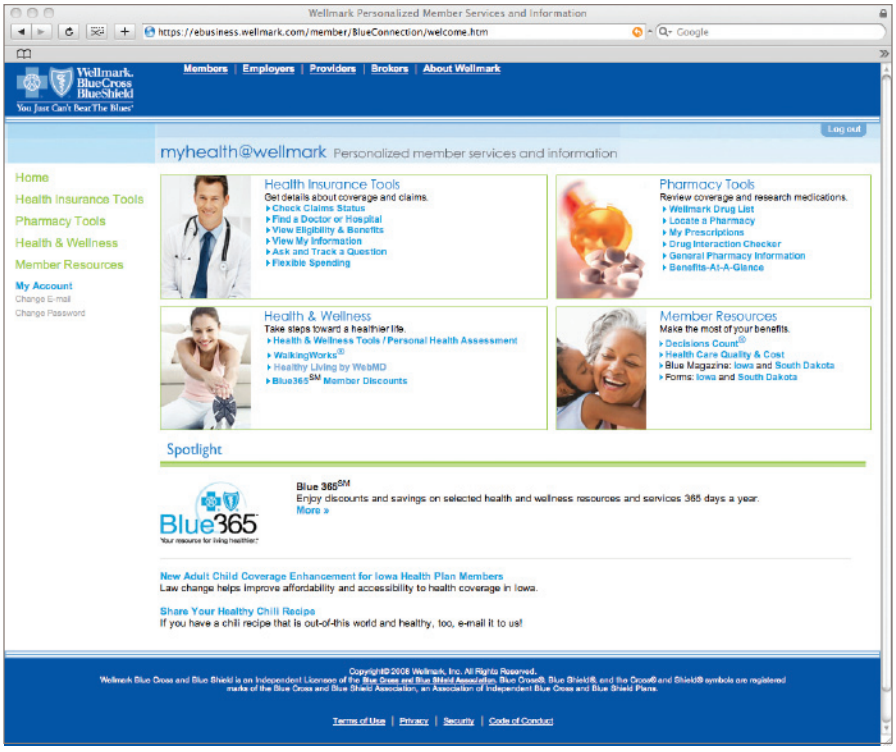
Wellmark's online tools at www.wellmark.com provide you convenient access to health plan information. Registration takes just a few minutes, and allows you to:

- Check the status of your most recent claims
- Get an overview of all your claims
- View your eligibility for services under your health plan
- Double-check deductible or out-of-pocket amounts
- Find a network doctor or hospital
- Order an ID card
- Learn about brand-name and generic drugs

Healthy Living Powered by WebMD®

Healthy Living gives you access to health and wellness information. Here you'll find:

- Comprehensive fitness and nutrition information
- Articles from health journals and magazines
- A symptom checker
- Personalized e-mail newsletters
- Health topics A - Z, the Medical Encyclopedia
- Self Care Centers with the latest information on specific conditions
- Interactive calculators, guides, and quizzes



Online tools provide convenient access to health plan information

Definitions

These are general definitions. This is not a contract. Please see your benefits certificate for contractual definitions as they pertain to your policy.

Actual Charge — The amount of money a doctor or supplier charges for a certain medical service or supply. This amount is often more than the amount Medicare approves.

Admitting Physician — The doctor responsible for admitting a patient to a hospital or other inpatient health facility.

Ambulatory Care — All types of health services that do not require an overnight hospital stay.

Ambulatory Surgical Center — A place other than a hospital that does outpatient surgery. At an ambulatory (in and out) surgery center, you may stay for only a few hours or for one night.

Assignment (Medicare Part B) — An agreement by a provider to accept Medicare's approved amount as full payment and not to bill the patient for any amounts over the Medicare-approved amount, except for deductibles, coinsurance amounts, or non-covered services. Payment is made directly to providers accepting assignment.

Beneficiary — A person enrolled in Medicare.

Benefit Period — The same as a calendar year. It begins on the day coverage goes into effect and starts over each January 1.

Carrier — The organization processing claims covered under Part B of Medicare.

Claim — A request to a carrier or intermediary by a beneficiary or provider acting on behalf of a beneficiary for payment of benefits.

Coinsurance — The percentage of medical expenses that a beneficiary will pay for covered services.

Coordination of Benefits — Process for determining the respective responsibilities of two or more health plans that have some financial responsibility for a medical claim.

Covered Services — Those medically necessary services and supplies qualifying for payment of benefits under your retiree insurance program.

Custodial Care — Means the type of care, wherever furnished, which is designed essentially to assist an individual to meet his or her daily living activities and is of a nature that does not require the continuing attention and assistance of licensed medical or trained paramedical personnel.

Examples of Custodial Care include, but are not limited to, the following activities:

a. Services that constitute personal care such as walking, getting in and out of bed, aid in bathing, dressing, feeding and other forms of assistance with normal bodily functions;

b. Preparation of special diets;

c. Supervision of medication that can usually be self-administered.

Custodial care is not a covered benefit of your retiree insurance coverage.

Deductible — The amount a beneficiary must pay for covered services before Medicare or retiree insurance benefits are available.

Durable Medical Equipment — Medical equipment that is ordered by a doctor for use in the home. These items must be reuseable, such as walkers, wheelchairs or hospital beds. DME is paid for under Medicare Part B and Part A for home-health services.

Enrollment Period — A certain period of time when you can join a Medicare health plan if it is open and accepting new Medicare members. If a health plan chooses to be open, it must allow all eligible people with Medicare to join.

Excess Charges — The difference between a doctor's or other health care provider's actual charge (which may be limited by Medicare or the state) and the Medicare-approved payment amount.

Exclusions — Items or services that Medicare does not cover, such as long-term care and custodial care in a nursing or private home.

Facility — A licensed, certified, and/or accredited facility that provides inpatient and outpatient services. An example of a facility is a hospital.

Formulary — A list of certain drugs and their proper dosages.

Home Health Agency (HHA) — A Medicare-approved or Joint Commission on Accreditation of Health Care Organizations (JCAHO) approved association or organization that provides skilled nursing care in the home that lasts two hours or less.

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

Hospital Insurance — The part of Medicare (also known as Part A) that helps pay for inpatient hospital care, some inpatient care in a skilled nursing facility, home health care and hospice care.

Intermediary — The name given to an organization that processes claims for Medicare Part A in a given area.

Maximum Allowable Fee —The amount Wellmark establishes, using various methodologies, for covered services.

Medical Insurance — The part of Medicare (also known as Part B) that helps pay for medically necessary physicians' services, outpatient hospital services, and a number of other medical services and supplies that are not covered by the hospital insurance part of Medicare, as well as some home health services.

Medically Necessary — Means a covered procedure, service, or supply that Wellmark Blue Cross and Blue Shield of Iowa considers eligible for benefits under the retiree insurance program and is all of the following:

- Appropriate and necessary for the diagnosis and treatment of illness or injury.
- Consistent with professionally recognized standards of health care and given at the right time in the right setting.
- Not more costly than alternative services that would be more effective for diagnosis and treatment of the condition.
- Enables the member to make reasonable progress in treatment.

Medicare — The federal government's health insurance program for people age 65 and older, and for individuals of any age entitled to monthly disability benefits under Social Security or Railroad Retirement Program.

Medicare's Approved Amount — The amount payable under Medicare for a covered service. Physicians and other providers who accept Medicare assignment agree to accept the Medicare approved amount as full payment for services provided to Medicare beneficiaries.

Medicare-Participating Provider — A physician or supplier who has signed an agreement to accept Medicare's approved amount as payment-in-full for covered services provided to the Medicare beneficiary. Payment will be made directly to a Medicare-participating provider, and the provider may not bill the difference between the billed charge and Medicare's approved amount to the beneficiary. Participating providers will submit claims for the beneficiary.

Medicare Non-Participating Provider — A physician or supplier who has chosen not to contract with Medicare to accept Medicare's approved amount as payment-in-full for covered medical services provided to beneficiaries. Such providers may bill patients for the difference between Medicare's approved amount and the billed charge, unless the provider has agreed to accept assignment on a particular claim. Payment for services provided by Medicare non-participating providers is made directly to the Medicare beneficiary when the provider does not accept assignment.

Non-assignment — Applies to claims for which the provider does not accept Medicare's approved amount as payment in full for covered services provided to Medicare beneficiaries; the payment is sent to the beneficiary, who then pays the provider.

Outpatient Facility — A facility that provides health and medical services to individuals who are not inpatients.

Skilled Nursing Facility — A specially qualified facility that provides continuous skilled nursing services as ordered and certified by an attending physician. A registered nurse (RN) must supervise services and supplies on a 24-hour basis.

The following pages contain charts that provide a general outline of your Medicare and your retiree insurance program benefits.

The itemized charts of covered services for your retiree insurance program show how your program complements your Medicare coverage. The charts identify hospital and medical services and explain:

- The portion of each service covered by Medicare Part A and Part B,
- The portion covered by your retiree insurance program, and
- The portion for which you will be responsible.

Medicare (Part A) Hospital Services PER BENEFIT PERIOD

Services	Medicare Pays	Wellmark Blue Cross and Blue Shield Pays	You Pay
Hospitalization [1] Semi-private room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,068	$1,068 (Part A deductible)	$0
61st thru 90th day	All but $267 a day	$267 a day	$0
91st day and after: — While using 60 lifetime reserve days	All but $534 a day	$534 a day	$0
— Once lifetime reserve days are used: Additional 365 days	$0	100% of Medicare eligible expenses	$0 [2]
Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care [1] You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $133.50 a day	Up to $133.50 a day	$0
101st thru 130th day	$0	All approved amounts	$0
131st day and after	$0	$0	All costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice Care Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

[1] A benefit period begins on the first day you receive services as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

[2] NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Basic Benefits."

NOTE: Medicare benefits are subject to change.

This is a general description of coverage. It is not a statement of contract. Actual coverage is subject to the terms and conditions specified in the Benefits Certificate and enrollment regulations in force when the Benefits Certificate becomes effective. For complete details of Medicare benefits and exclusions, you may obtain a copy of Medicare & You from the Social Security Administration, or visit www.medicare.gov.

Medicare (Part B) Medical Services PER CALENDAR YEAR

Services	Medicare Pays	Wellmark Blue Cross and Blue Shield Pays	You Pay
Medical Expenses IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $135 of Medicare-Approved Amounts [3]	$0	$135 (Part B deductible)	$0
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved Amounts)	$0	$0	All Part B excess charges
Blood			
First 3 pints	$0	All costs	$0
Next $135 of Medicare-Approved Amounts [3]	$0	$135 (Part B deductible)	$0
Remainder of Medicare-Approved Amounts	80%	20%	$0
Clinical Laboratory Services BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0
Home Health Care MEDICARE-APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable Medical Equipment: — First $135 of Medicare-Approved Amounts [3]	$0	$135 (Part B deductible)	$0
— Remainder of Medicare-Approved Amounts	80%	20%	$0

[3] Once you have been billed $135 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Other Benefits Not Covered by Medicare

Services	Medicare Pays	Wellmark Blue Cross and Blue Shield Pays	You Pay
Foreign Travel Emergency Care NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
Charges	$0	75% of approved charges	25% of approved charges
Preventive Medical Care Benefit [4] NOT COVERED BY MEDICARE			
Some annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare			
Routine mammography screening per calendar year	After $135 (Part B deductible), 80% of Medicare-approved amount for one screening every year for women 65 and older	One mammography screening per year for women 65 or older up to maximum allowable fee amount, less any amount paid by Medicare	$0
Additional Charges	$0	$0	All costs

[4] Medicare benefits are subject to change. Please consult *Medicare & You* or visit the Medicare web site at *www.medicare.gov*.

Questions regarding your Retiree Health Plan should be directed to Wellmark Blue Cross and Blue Shield of Iowa by calling toll-free **1-800-245-6106**.

Wellmark® BlueCross BlueShield® of Iowa

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