Idaho Independent Intergovernmental Authority (III-A) Trust Employee Benefit Plan

Effective Date: October 1, 2024

Blue Cross of Idaho has been hired as the Contract Administrator by the Trust to perform claims processing and other specified administrative services in relation to the Plan. Blue Cross of Idaho is a trade name for Blue Cross of Idaho Health Service, Inc., an independent licensee of the Blue Cross and Blue Shield Association.

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HOW TO SUBMIT CLAIMS

A Participant must submit a claim to the Contract Administrator (Blue Cross of Idaho) in order to receive benefits for Covered Services. Claims must be submitted within 12 months of the date of service. There are two ways for a Participant to submit a claim:

1. The health care Provider (hospital, doctor, or other facility or specialist) can file the claims for the Participant. Most Providers will submit a claim on a Participant's behalf if the Participant shows them the identification card and asks them to send the Contract Administrator the claim, or submit the claim to the local Blue Cross/Blue Shield plan in the area where services were received.

2. The Participant can send the Contract Administrator the claim or submit the claim to the local Blue Cross/Blue Shield plan in the area where services were received.

To File a Participant's Own Claim
If a Provider prefers that a Participant file the claim, here is the procedure to follow:

1. Ask the Provider for an itemized billing. The itemized billing should show each service received and its procedure code and its diagnosis code, the date each service was furnished, and the charge for each service. The Contract Administrator cannot accept billings that only say "Balance Due," "Payment Received" or some similar statement.

2. Obtain a Member Claim Form from the Contract Administrator's Website, www.bcidaho.com, from the Provider or any of the Contract Administrator's offices, and follow the instructions. Use a separate billing and Member Claim form for each patient.

3. Attach the billing to the Member Claim Form and send it to:

   Blue Cross of Idaho Claims Control
   Blue Cross of Idaho
   PO Box 7408
   Boise, ID 83707

For assistance with claims or health benefit information, please call the Contract Administrator's Customer Service at 1-800-627-1188 or (208) 331-7347.

How Blue Cross of Idaho Notifies the Participant
The Contract Administrator will send the Participant an Explanation of Benefits (EOB) by mail or electronically, if the Participant has consented to electronic delivery, once the claim is processed. The EOB will show all the payments the Contract Administrator made on behalf of the Plan and to whom the payments were sent. It will also explain any charges the Contract Administrator did not pay in full. If a Participant would like a paper copy of their EOB, they may request one from the Contract Administrator's Customer Service.

CONTACT INFORMATION FOR THE CONTRACT ADMINISTRATOR

For assistance with claims or health benefit information, please call Customer Service at (800) 627-1188 or (208) 331-7347.

For general information, please contact your local Contract Administrator's office:

Meridian
Customer Service Department
3000 East Pine Avenue
Meridian, ID 83642

2929 W. Navigator Drive, Suite 140
Meridian, ID 83642

Mailing Address
PO Box 7408
Boise, ID 83707
(208) 387-6683 (Boise Area)
1-800-365-2345

Coeur d'Alene
1812 N. Lakewood Dr., Suite 200
Coeur d'Alene, ID 83814
(208) 666-1495

Pocatello
852 W. Quinn Rd.
Chubbuck, ID 83202
(208) 232-6206

Idaho Falls
3630 S. 25th E., Suite 1
Idaho Falls, ID 83404
(208) 522-8813

Twin Falls
428 Cheney Dr. W., Suite 101
Twin Falls, ID 83301
(208) 733-7258

ELIGIBILITY AND ENROLLMENT SECTION

I. Eligibility and Enrollment

The Employer decides which categories of its Employees and Dependents will have the opportunity to apply for coverage under the Plan in accordance with the Employer's employee handbook. The Employer will determine if there are certain probationary periods that must be satisfied before a new Eligible Employee can qualify for coverage under the Plan. Please contact your manager of employee benefits for the probationary period and any other restrictions applicable.

A. Eligible Employee

To qualify as an Eligible Employee, a person must be and remain a full-time employee or partner of the Employer who regularly works a minimum required hours per week established by the Employer and is paid on a regular, periodic basis through the Plan Sponsor's payroll system**,** or a retiree who is under the age of sixty-five (65) years and has met the eligibility requirements for retirement as determined by the Plan Sponsor; or for an elected official who is specifically stated as eligible in the individual Agency's Personnel Policy. **Please see your employee handbook for complete eligibility requirements.**

B. Eligible Dependent

The Employer decides which categories of dependents are eligible for coverage as described in the employee handbook. **Please see your employee handbook for complete eligibility requirements.** Notwithstanding any other provision of the Plan, if the benefits of the Plan are not available to certain dependents and certain categories of dependents are not eligible to enroll or receive benefits, references in this Plan Document and Summary of Health Care Benefits do not apply.

If the Plan provides coverage for an Eligible Dependent Spouse and/or Eligible Dependent Child(ren) a person must be and remain one (1) of the following:

1. The Enrollee's spouse under a legally valid marriage.
2. The Enrollee's or the Enrollee's spouse's natural child, stepchild, legally adopted child, child placed with the Enrollee for adoption, or child for whom the Enrollee or the Enrollee's spouse has court-appointed guardianship or custody. The child must be under the age of twenty-six (26).
3. A child as described in the first sentence of subparagraph two (2) who has attained age twenty-six (26) provided:
    a) The child is medically certified as incapable of self-sustaining employment due to an intellectual disability or physical handicap that began prior to age twenty-six (26);
    b) The child is chiefly dependent upon the Enrollee or the Enrollee's spouse for support and maintenance; and
    c) The Enrollee submits proof of such child's incapacity and dependency as described in this subparagraph three (3) within thirty-one (31) days of such child's attainment of age twenty-six (26) and as subsequently required by the Contract Administrator and/or the Employer at reasonable intervals.

An Enrollee must notify the Plan Sponsor within thirty (30) days when a dependent no longer qualifies as an Eligible Dependent. Coverage for the former Eligible Dependent will terminate on the last day of the month in which the change in eligibility status took place.

C. Annual Open Enrollment Periods

Applications for coverage for an Eligible Employee will only be accepted during the Trust's annual Open Enrollment Period, during the Eligible Employee's Initial Enrollment Period, or during a Special Enrollment Period as described in this section. If an Eligible Employee does not apply for coverage during these time periods, they must wait until the next Open Enrollment Period or Special Enrollment Period.

D. Initial Enrollment Period

The Initial Enrollment Period is ninety (90) days for Eligible Employees and Eligible Dependents. The Initial Enrollment Period begins on the date the Eligible Employee or Eligible Dependent first becomes eligible for coverage under this Plan Document and Summary of Health Care Benefits.

E. Enrollment of Eligible Dependents

1. For an Eligible Employee to enroll themself and any Eligible Dependents for coverage under this Plan Document and Summary of Health Care Benefits (or for an Enrollee to enroll Eligible Dependents for coverage) the Eligible Employee or Enrollee, as the case may be, must complete an III-A Trust application and submit it to the Plan Sponsor.
2. Newborn/Adoption---When a newborn child is added and the monthly Contribution changes, a full month's Contribution is required. An Enrollee's newborn Dependent, including adopted newborn children who are placed with the adoptive Enrollee within sixty (60) days of the adopted child's date of birth, are covered under this Plan from and after the date of birth for sixty (60) days.
    A. Contribution for the first sixty (60) days of coverage is due not less than thirty-one (31) days following receipt of a billing for the required Contribution. In order to continue coverage beyond the sixty (60) days outlined above, the Enrollee must complete an enrollment application within sixty (60) days of date of birth and submit the required Contribution, for the first sixty (60) days, within thirty-one (31) days of the date monthly billing is received and a notice of Contribution is provided to the Enrollee from the Trust.
    B. If the date of adoption or the date of placement for adoption of a child is more than sixty (60) days after the child's date of birth, the Effective Date of coverage will be the date of adoption or the date of placement for adoption. In this Plan Document and Summary of Health Care Benefits, 'child' means an individual who has not attained age twenty-six (26) years as of the date of the adoption or placement for adoption. In this Plan Document and Summary of Health Care Benefits, "placed for adoption" means physical placement in the care of the adoptive Enrollee, or in those circumstances in which such physical placement is prevented due to the medical needs of the child requiring placement in a medical facility, it means when the adoptive Enrollee signs an agreement for adoption of the child and signs an agreement assuming financial responsibility for the child.

F. Effective Dates of Coverage

Subject to receiving the applicable Contribution payment:

1. If the Eligible Employee or Eligible Dependent enrolled during their Initial Enrollment Period or the Trust's Open Enrollment Period, the Effective Date of coverage for an Eligible Employee and any Eligible Dependents listed on the Eligible Employee's application is the date indicated by the Trust.
2. If enrollment is requested during a Special Enrollment Period due to the loss of Minimum Essential Coverage or marriage, the Effective Date of coverage will be the first day of the month following the marriage or loss of coverage.
3. The Effective Date of coverage for enrollment requested during a Special Enrollment Period will be the date of birth for a newborn natural child or a newborn child adopted or placed for adoption within sixty (60) days of the child's date of birth.
4. For other enrollment requested though a Special Enrollment Period, coverage will begin on the first day of the following month.

G. Late Enrollee

If an Eligible Employee or Eligible Dependent does not enroll during the applicable initial enrollment period described in Paragraph D. of this section, or during a special enrollment period described in Paragraph H. of this section, the Eligible Employee or Eligible Dependent is a Late Enrollee. Following the receipt and acceptance of a completed enrollment application, the Effective Date of coverage for a Late Enrollee will be the date of the next Plan Date.

H. Special Enrollment Periods/Qualifying Events

Outside of the Eligible Employee's Initial Enrollment Period or annual Open Enrollment Period, an Eligible Employee or Eligible Dependent will not be considered a Late Enrollee and may enroll for coverage, unless otherwise noted, within sixty (60) days of the occurrence of one of the following events:

1. The Eligible Employee or Eligible Dependent meets each of the following:
   a) The individual was covered under Minimum Essential Coverage at the time of the initial enrollment period.
   b) The individual involuntarily lost coverage under Minimum Essential Coverage.
   c) The individual requests enrollment within sixty (60) days after termination of the Minimum Essential Coverage.
2. Addition of an Eligible Dependent through marriage, birth, adoption or placement of adoption and coverage is requested no later than sixty (60) days after the event.
3. A court has issued a Qualified Medical Child Support Order (QMCSO) requiring that coverage be provided for an Eligible Dependent by an Enrollee, and application for enrollment is made within thirty (30) days after issuance of the QMCSO.
4. The Eligible Employee and/or Eligible Dependent become eligible for financial assistance under Medicaid or the Children's Health Insurance Program (CHIP) and coverage is requested no later than sixty (60) days after the date the Eligible Employee and/or Eligible Dependent is determined to be eligible for such assistance.
5. Coverage under Medicaid or CHIP for an Eligible Employee and/or Eligible Dependent is terminated as a result of loss of eligibility for such coverage, and coverage is requested no later than sixty (60) days after the date of termination of such coverage.

II. Trust Contribution and Enrollment Requirements

A. All applications submitted to the Trust by the Plan Sponsor now or in the future, will be for Eligible Employees or Eligible Dependents only.

B. The Trust agrees to be responsible for and make the total required payment to the Contract Administrator as provided in the Administrative Services Agreement. The Trust further agrees that no other hospital, medical or surgical group coverage will be offered to employees during the term of this Plan Document and Summary of Health Care Benefits, unless required by State or Federal law.

C. The Trust agrees it will pay one hundred percent (100%) of the amount paid in benefits for all Participants under this Plan Document and Summary of Health Care Benefits, except as modified by the Administrative Services Agreement.

D. Before the Effective Date of the change, the Plan Sponsor shall submit all eligibility changes for Enrollees and Eligible Dependents to the Trust. It is the Plan Sponsor's responsibility to verify that all Participants are eligible for coverage as specified in this Plan Document and Summary of Health Care Benefits.

E. If the Trust maintains regular monthly payments with the regular Trust billing, an Employer approved temporary leave of absence may continue for a maximum of 120 days and then cease. On its regular billing, the Trust will notify the Contract Administrator of the Enrollee's date of departure for the leave of absence, and shall continue its regular Contribution for the Enrollee's coverage during the leave of absence.

III. Qualified Medical Child Support Order

The Trust will extend benefits to an Eligible Employee's non-custodial child, as may be required by a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN). Please contact the Employer for its QMCSO procedures. The Contract Administrator does not administer request for coverage or make determinations regarding whether a purported QMCSO or NMSN is qualified or not.

INPATIENT NOTIFICATION SECTION

This section describes procedures that should be followed in order for Participants to receive the maximum benefits available for Covered Services. As specified, Non-Emergency Preadmission Notification or Emergency Admission Notification is required for all Inpatient services.

NOTE: Some Inpatient services also require the Provider to obtain Prior Authorization. Please refer to the Prior Authorization Section.

I. Non-Emergency Preadmission Notification

Non-Emergency Preadmission Notification is a notification to the Contract Administrator by the Participant and is required for all Inpatient admissions except Covered Services subject to Emergency or Maternity delivery Admission Notification. A Participant should notify the Contract Administrator of all proposed Inpatient admissions as soon as they know they will be admitted as an Inpatient. The notification should be made before any Inpatient admission. Non-Emergency Preadmission Notification informs the Contract Administrator, or a delegated entity, of the Participant's proposed Inpatient admission to a Licensed General Hospital, Alcohol or Substance Use Disorder Treatment Facility, Psychiatric Hospital, or any other Facility Provider. This notification alerts the Contract Administrator of the proposed stay. When timely notification of an Inpatient admission is provided by the Participant to the Contract Administrator, payment of benefits is subject to the specific benefit levels, limitations, exclusions and other provisions of this Plan Document and Summary of Health Care Benefits.

For Non-Emergency Preadmission Notification call the Contract Administrator at the telephone number listed on the back of the Participant's Identification Card.

II. Emergency Admission Notification

When an Emergency Admission occurs for Emergency Medical Conditions and notification cannot be completed prior to admission due to the Participant's condition, the Participant, or their representative, should notify the Contract Administrator within seventy-two (72) hours of the admission. If the admission is on a weekend or legal holiday, the Contract Administrator should be notified by the end of the next working day after the admission.

This notification alerts the Contract Administrator to the emergency stay.

III. Continued Stay Review

The Contract Administrator will contact the hospital utilization review department and/or the attending Physician regarding the Participant's proposed discharge. If the Participant will not be discharged as originally proposed, the Contract Administrator will evaluate the Medical Necessity of the continued stay and approve or disapprove benefits for the proposed course of Inpatient treatment. Payment of benefits is subject to the specific benefit levels, limitations, exclusions and other provisions of this Plan Document and Summary of Health Care Benefits.

IV. Discharge Planning

The Contract Administrator will provide information about benefits for various post-discharge courses of treatment.

PRIOR AUTHORIZATION SECTION

NOTICE: ***Prior Authorization is required to determine if the services listed in the Attachment A of the Benefits Outline are Medically Necessary and a Covered Service. If Prior Authorization has not been obtained to determine Medical Necessity, services may be subject to denial. Any dispute involved in the Contract Administrator's Medical Necessity decision must be resolved by use of the appeal process described in this Plan Document and Summary of Health Care Benefits.***

If Non-Medically Necessary services are performed by Contracting Providers, without the Prior Authorization, and benefits are denied, the cost of said services are not the financial responsibility of the Participant. The Participant is financially responsible for Non-Medically Necessary services performed by a provider who does not have a Provider contract with the Contract Administrator, Blue Cross of Idaho.

Prior Authorization is a request by the Participant's Contracting Provider to the Contract Administrator, or delegated entity, for authorization of a Participant's proposed treatment. The Contract Administrator may review medical records, test results and other sources of information to ensure that it is a Covered Service and make a determination as to Medical Necessity or alternative treatments.

Please refer to Attachment A of the Benefits Outline, check the Contract Administrator's Website at www.bcidaho.com, or call Customer Service at the telephone number listed on the back of the Participant's Identification Card to determine if the Participant's proposed services require Prior Authorization. To request Prior Authorization, the Contracting Provider must notify the Contract Administrator of the Participant's intent to receive services that require Prior Authorization.

The notification may be completed by telephone call or in writing and must include the information necessary to establish that the proposed services are Covered Services under the Participant's Plan and Medically Necessary. The Contract Administrator will respond to a request for Prior Authorization received from either the Provider or the Participant within seventy-two (72) hours for an expedited request or fourteen (14) days for a standard request of the receipt of the medical information necessary to make a determination.

Noncontracting Providers: Please refer to Attachment A of the Benefits Outline, check the Contract Administrator Website at www.bcidaho.com, or call Customer Service at the telephone number listed on the back of the Participant's Identification Card to determine if the proposed services require Prior Authorization. The Participant is responsible for obtaining Prior Authorization when seeking treatment from a Noncontracting Provider. The Participant is financially responsible for services performed by a Noncontracting Provider when those services are determined to be not Medically Necessary. The Participant is responsible for notifying the Contract Administrator if the proposed treatment will be provided by a Noncontracting Provider.

Prior Authorization is not a guarantee of payment. It is a pre-service determination of Medical Necessity based on information provided to the Contract Administrator at the time the Prior Authorization request is made. The Contract Administrator, on behalf of the Plan Sponsor, retains the right to review the Medical Necessity of services, eligibility of services and benefit limitations and exclusions after services are received.

COMPREHENSIVE MAJOR MEDICAL BENEFITS SECTION

This section specifies the benefits a Participant is entitled to receive for the Covered Services described, or conditions that must be satisfied to qualify for benefits, subject to the other provisions of this Plan Document and Summary Plan Documents.

I. Benefit Period

The Benefit Period is the specified period of time during which a Participant accumulates annual benefit limits, Deductible amounts and Out-of-Pocket Limits. Please see the cover page of this Plan Document and Summary Plan Documents for the Benefit Period. If the Participant's Effective Date is after the Plan Date, the initial Benefit Period for that Participant may be less than twelve (12) months.

The Benefit Period for Hospice Covered Services is a continuous six (6) month period that begins when a Hospice Plan of Treatment is approved by the Contract Administrator. The Participant may apply to the Contract Administrator for an extension of the Hospice Benefit Period.

II. Deductible

A. Individual

The Individual Deductible is shown in the Benefits Outline.

B. Family

The Family Deductible is shown in the Benefits Outline.

III. Out-of-Pocket Limit

The Out-of-Pocket Limit is shown in the Benefits Outline. Eligible Out-of-Pocket expenses include only the Participant's Deductible, Copayments and Cost Sharing, if applicable, for eligible Covered Services. When the Out-of-Pocket Limit is met, benefits payable for Covered Services increase to 100% of the Maximum Allowance during the remainder of the Benefit Period, except for services that do not apply to the limit as listed in the Plan. If a Participant is admitted as an Inpatient at the end of a Benefit Period and the hospitalization continues uninterrupted into the succeeding Benefit Period, all eligible Out-of-Pocket expenses incurred for Inpatient Hospital Services are considered part of the Benefit Period in which the date of admission occurred. The In-Network Out-of-Pocket Limit also includes amounts covered under the Plan's prescription drug coverage that is administered by a third-party Pharmacy Benefit Manager (PBM) selected by the Employer, not the Contract Administrator (Blue Cross of Idaho). The Contract Administrator relies on the information submitted by the Employer, or the Employer's designed PBM, to provide accurate pharmacy cost-sharing information and is not responsible for any discrepancies.

A. Out-of-Pocket expenses associated with the following are not included in the In-Network Out-of-Pocket Limit:
   1. Amounts that exceed the Maximum Allowance.
   2. Amounts that exceed benefit limits.
   3. Services covered under a separate Plan, if any, except as specified above.
   4. Noncovered services or supplies.

B. Out-of-Pocket expenses associated with the following are not included in the Out-of-Network Out-of-Pocket Limit:
   1. Amounts that exceed the Maximum Allowance.
   2. Amounts that exceed benefit limits.
   3. Dental care Covered Services.
   4. Services covered under a separate Plan, if any, except as specified above.
   5. Noncovered services or supplies.
   6. Vision care Covered Services.

IV. Providers

All Providers and Facilities must be licensed, certified, accredited and/or registered, where required, to render Covered Services. For the purposes of this Summary of Health Care Benefits, Providers include any facility or individual who provides a Covered Service while operating within the scope of their license, certification, accreditation and/or registration under applicable state law, unless exempted by federal law.

V. Covered Services

Note: In order to receive benefits, some Covered Services require Prior Authorization. Please review the Prior Authorization Section for more specific details.

To be eligible for benefits, Covered Services must be Medically Necessary and must be provided to an eligible Participant under the terms of this Plan Document and Summary of Health Care Benefits.

The Benefits Outline, incorporated into this Plan Document and Summary of Health Care Benefits, is an easy reference document that contains general payment information and a descriptive list of Covered Services. Benefits for Covered Services may be subject to Copayments, Deductibles, Cost Sharing, visit limits and other limits specified in the Benefits Outline.

A. Applied Behavioral Analysis (ABA) - Outpatient

Benefits are covered for ABA services by Providers, including those rendered by a Provider who has obtained a Board Certified Behavioral Analysis (BCBA) certification issued by the Behavioral Analyst Certification Board.

B. Hospital Services

1. **Inpatient Hospital Services**

a) **Room and Board and General Nursing Service**

Room and board, special diets, the services of a dietician, and general nursing service when a Participant is an Inpatient in a Licensed General Hospital is covered as follows:

(1) A room with two (2) or more beds is covered. If a private room is used, the benefit provided in this section for a room with two (2) or more beds will be applied toward the charge for the private room. Any difference between the charges is a noncovered expense and is the sole responsibility of the Participant.

(2) If isolation of the Participant is: (a) required by the law of a political jurisdiction, or (b) required to prevent contamination of either the Participant or another patient by the Participant, then payment for approved private room isolation charges shall be in place of the benefits for the daily room charge stated in paragraph one (1).

(3) Benefits for a bed in a Special Care Unit shall be in place of the benefits for the daily room charge stated in paragraph one (1).

(4) A bed in a nursery unit is covered.

b) **Ancillary Services**

Licensed General Hospital services and supplies including:

(1) Use of operating, delivery, cast, and treatment rooms and equipment.

(2) Prescribed drugs administered while the Participant is an Inpatient.

(3) Administration and processing of whole blood and blood products when the whole blood or blood products are actually used in a transfusion for a Participant; whole blood or blood plasma that is not donated on behalf of the Participant or replaced through contributions on behalf of the Participant.

(4) Anesthesia, anesthesia supplies and services rendered by the Licensed General Hospital as a regular hospital service and billed by the same hospital in conjunction with a procedure that is a Covered Service.

(5) All medical and surgical dressings, supplies, casts, and splints that have been ordered by a Physician and furnished by a Licensed General Hospital. Specially constructed braces and supports are not Covered Services under this section.

(6) Oxygen and administration of oxygen.

(7) Patient convenience items essential for the maintenance of hygiene provided by a Licensed General Hospital as a regular hospital service in connection with a covered hospital stay. Patient convenience items include, but are not limited to, an admission kit, disposable washbasin, bedpan or urinal, shampoo, toothpaste, toothbrush, and deodorant.

(8) Diagnostic Services and Therapy Services.

If Diagnostic Services or Therapy Services furnished through a Licensed General Hospital are provided by a Physician under contract with the same hospital to perform such services and the Physician bills separately, then the Physician's services are a Covered Service.

2. **Outpatient Hospital Services**

a) **Emergency Services**

Medical care to treat an Emergency Medical Condition or an Accidental Injury. Emergency room services include:

- Emergency room Physician and Facility services;
- Freestanding Emergency Department;
- Post-Stabilization Care Services;
- Equipment, supplies and drugs used in the emergency room;
- Inpatient Admission that is necessary even after Stabilization.
- Services and exams for Stabilization of an Emergency Medical Condition; and
- equipment and devices, telemedicine services, Diagnostic Services, preoperative and postoperative services, and other items and services, rendered during the Emergency room visit.

For purposes of this section, Stabilization means that no material deterioration of the Emergency Medical Condition is likely to result from or occur during the transfer of the Participant from a facility.

b) **Surgery**

Licensed General Hospital or Ambulatory Surgical Facility services and supplies including removal of sutures, anesthesia, anesthesia supplies and services. The furnished supplies and services must be in conjunction with a Covered Service rendered by an employee of one (1) of the above facilities who is not the surgeon or surgical assistant.

3. **Special Services**

a) **Preadmission Testing**

Tests and studies required with the Participant's admission and accepted or rendered by a Licensed General Hospital on an Outpatient basis prior to a scheduled admission as an Inpatient, if the services would have been available to an Inpatient of a Licensed General Hospital. Preadmission Testing does not include tests or studies performed to establish a diagnosis.

Preadmission Testing benefits are limited to Inpatient admissions for Surgery. Preadmission Testing must be conducted within seven (7) days prior to a Participant's Inpatient admission.

Preadmission Testing is a Covered Service only if the services are not repeated when the Participant is admitted to the Licensed General Hospital as an Inpatient, and only if the tests and charges are included in the Inpatient medical records.

No benefits for Preadmission Testing are provided if the Participant cancels or postpones the admission to the Licensed General Hospital as an Inpatient. If the Licensed General Hospital or Physician cancels or postpones the admission then benefits are provided.

b) Hospital benefits may be provided for dental extractions, or other dental procedures if certified by a Physician that a non-dental medical condition requires hospitalization to safeguard the health of the Participant. Non-dental conditions that may receive hospital benefits are:

(1) Brittle diabetes.
(2) History of a life-endangering heart condition.
(3) History of uncontrollable bleeding.
(4) Severe bronchial asthma.
(5) Children under ten (10) years of age who require general anesthetic.
(6) Other non-dental life-endangering conditions that require hospitalization, subject to approval by the Contract Administrator.

C. Skilled Nursing Facility

Benefits provided to an Inpatient of a Licensed General Hospital are also provided for services and supplies customarily rendered to an Inpatient of a Skilled Nursing Facility, including twenty-four (24) hour onsite nursing services. If a Participant is admitted for Skilled Nursing Services, the contract terms in effect on the date of the admission will apply to the Skilled Nursing Facility visit for the entire Inpatient stay. However, if a Participant's admission crosses Benefit Periods and the previous Benefit Period limit has been exhausted, the Contract Administrator will credit the new Benefit Period limit without discharge. Skilled Nursing Facility care does not include Custodial Care, supervised living, or other similar facilities providing primarily a supportive and/or recreational environment, even if some Skilled Nursing Care is provided in such facilities.

No benefits are provided when the care received consists primarily of:

1. Room and board, routine nursing care, training, supervisory, or Custodial Care.
2 Care for senile deterioration, mental deficiency or intellectual disability.
3. Care for Mental or Nervous Conditions, Alcoholism or Substance Use Disorder or Addiction.
4. Maintenance Physical Therapy, Hydrotherapy, Speech Therapy, or Occupational Therapy.

D. Ambulance Transportation Service

Ambulance transportation services are covered for Medically Necessary transportation of a Participant within the local community by Ambulance under the following conditions:

1. From a Participant's home or scene of Accidental Injury or Emergency Medical Condition to a Licensed General Hospital.
2. Between Licensed General Hospitals.
3. Between a Licensed General Hospital and a Skilled Nursing Facility.
4. From a Licensed General Hospital to the Participant's home.
5. From a Skilled Nursing Facility to the Participant's home.

For purposes of 1., 2. and 3. above, if there is no facility in the local community that can provide Covered Services appropriate to the Participant's condition, then Ambulance Transportation Service means transportation to the closest facility that can provide the necessary service.

Air Ambulance transportation services are covered only when Medically Necessary when geographic restraints prevent Ground Ambulance transportation to the nearest facility that can provide Covered Services appropriate to the Participants condition, or ground transportation would put the health and safety of the Participant at risk.

Ground Ambulance and Air Ambulance services that are not for an Emergency Medical Conditions must be Medically Necessary and require Prior Authorization.

E. Mental Health and Substance Use Disorder Services

1. Covered Mental Health and Substance Use Disorder Services include Intensive Outpatient Program (IOP), Partial Hospitalization Program (PHP), Residential Treatment Center, psychological testing/neuropsychological evaluation testing and Electroconvulsive Therapy (ECT).
2. **Inpatient Mental Health and Substance Use Disorder Care—**The benefits provided for Inpatient hospital services and Inpatient medical services in this section are also provided for the care of Mental or Nervous Conditions, Alcoholism, Substance Use Disorder or Addiction, or any combination of these.
3. **Outpatient Mental Health and Substance Use Disorder Care—**The benefits provided for Outpatient Hospital Services and Outpatient Medical Services in this section are also

provided for Mental or Nervous Conditions, Alcoholism, Substance Use Disorder or Addiction, or any combination of these. The use of Hypnosis to treat a Participant's Mental or Nervous Condition is a Covered Service.

4. **Outpatient Psychotherapy Services—**Covered Services include professional office visit services, family, individual and/or group therapy.

F. Maternity Services

Nursery care of a newborn infant is not a maternity service. Diagnostic x-ray and laboratory services related to pregnancy, childbirth or, miscarriage are covered.

1. **Normal Pregnancy**

   Normal Pregnancy includes all conditions arising from pregnancy or delivery, including any condition usually associated with the management of a difficult pregnancy that is not defined below as an Involuntary Complication of Pregnancy.

2. **Involuntary Complications of Pregnancy**

   a) Involuntary Complications of Pregnancy include, but are not limited to:

      (1) Cesarean section delivery, ectopic pregnancy that is terminated, spontaneous termination of pregnancy that occurs during a period of gestation in which a viable birth is not possible (miscarriage), puerperal infection, and eclampsia.

      (2) Conditions requiring Inpatient confinement (when the pregnancy is not terminated), the diagnoses of which are distinct from pregnancy but are adversely affected or are caused by pregnancy. These conditions include acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, but do not include false labor, occasional spotting, Physician-prescribed bed rest during pregnancy, morning sickness, hyperemesis gravidarum, preeclampsia, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy.

3. If you have a birth, benefits for any hospital length of stay in connection with childbirth for the mother or newborn child will include forty-eight (48) hours following a vaginal delivery and ninety-six (96) hours following a cesarean section delivery. Federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than forty-eight (48) hours or ninety-six (96) hours as applicable. For stays in excess of forty-eight (48) hours or ninety-six (96) hours, additional benefits may be available under the terms of subsection, "Continued Stay Review", found in the Inpatient Notification Section of this Plan Document and Summary of Health Care Benefits.

G. Transplant Services

1. **Autotransplants**

   Autotransplants of arteries, veins, ear bones (ossicles), cartilage, muscles, skin, hematopoietic, and tendons; teeth or tooth buds, and other autotransplants as Medically Necessary.

   The applicable benefits provided for hospital and Surgical/Medical Services are provided only for a recipient of Medically Necessary Autotransplant Services. Autologous blood transfusion, FDA approved mechanical or biological heart valves and implanting of artificial pacemakers are not considered Transplants and are a Covered Service if Medically Necessary.

2. **Transplants**

   Transplants of corneas, kidneys, bone marrow, livers, hearts, lungs, pancreas, islet tissue, hematopoietic, heart/lung and pancreas/kidney combinations, and other solid organ or tissue Transplants or combinations, and other Transplants as Medically Necessary.

   a) The applicable benefits provided for hospital and Surgical/Medical Services are provided for a recipient of Medically Necessary Transplant Services.

b) The recipient must have the Transplant performed at an appropriate Recognized Transplant Center to be eligible for benefits for Transplant(s). If the recipient is eligible for Medicare, the recipient must have the Transplant performed at a Recognized Transplant Center that is approved by the Medicare program for the requested Transplant Covered Services.

c) If the recipient is eligible to receive benefits for these transplant services, Organ Procurement charges are paid for the donor (even if the donor is not a Participant). Benefits for the donor will be charged to the recipient's coverage.

d) A travel allowance may be available for the Participant and one adult caregiver for those Participants traveling to a Blue Distinction Centers for Transplants (BDCT), or in the case of a kidney transplant from a Recognized Transplant Center. Transplant Services must be Prior Authorized by the Contract Administrator. The Participant will be notified of their eligibility for this travel allowance upon Prior Authorization of the scheduled Transplant services.

3. **Exclusions and Limitations**

In addition to any other exclusions and limitations of the Plan, the following exclusions and limitations apply to Transplant or Autotransplant services.

No benefits are available for the following:

a) Transplants of brain tissue or brain membrane, intestine, pituitary and adrenal glands, hair Transplants, or any other Transplant not specifically named as a Covered Service in this section; or for CAR T Cell or Artificial Organs including but not limited to, artificial hearts or pancreases.

b) Any eligible expenses of a donor related to donating or transplanting an organ or tissue unless the recipient is a Participant who is eligible to receive benefits for Transplant services.

c) The cost of a human organ or tissue that is sold rather than donated to the recipient.

d) Transportation costs including but not limited to, Ambulance Transportation Service or air service for the donor, or to transport a donated organ or tissue.

e) Living expenses for the recipient, donor, or family members, except as specifically listed as a Covered Service in the Plan.

f) Costs covered or funded by governmental, foundation or charitable grants or programs; or Physician fees or other charges, if no charge is generally made in the absence of health coverage or insurance coverage.

g) Any complication to the donor arising from a donor's Transplant Surgery is not a covered benefit under the transplant recipient's health plan or policy. If the donor is a Contract Administrator (Blue Cross of Idaho) Participant, eligible to receive benefits for Covered Services, benefits for medical complications to the donor arising from Transplant Surgery will be allowed.

h) Costs related to the search for a suitable donor.

i) No benefits are available for services, expenses, or other obligations of or for a deceased donor (even if the donor is a Participant).

H. Surgical/Medical Services

1. **Surgical Services**

a) **Surgery**—Surgery performed by a Physician or other Professional Provider.

b) **Multiple Surgical Procedures**—benefits for multiple surgical procedures performed during the same operative session by one (1) or more Physicians or other Professional Providers are calculated based upon the Contract Administrator's Maximum Allowance and payment guidelines.

c) **Surgical Supplies**—when a Physician or other Professional Provider performs covered Surgery in the office, benefits are available for a sterile suture or Surgery tray normally required for minor surgical procedures.

d) **Surgical Assistant**—Medically Necessary services rendered by a Physician or other appropriately qualified surgical assistant who actively assists the operating surgeon in the performance of covered Surgery where an assistant is required. The percentage of the Maximum Allowance that is used as the actual Maximum Allowance to calculate the amount of payment under this section for Covered

Services rendered by a surgical assistant is 20% for a Physician Assistant and 10% for other appropriately qualified surgical assistants.

e) **Anesthesia**—in conjunction with a covered procedure, the administration of anesthesia ordered by the attending Physician and rendered by a Physician or other Professional Provider. The use of Hypnosis as anesthesia is not a Covered Service. General anesthesia administered by the surgeon or assistant surgeon is not a Covered Service.

f) **Second and Third Surgical Opinion**

(1) Services consist of a Physician's consultative opinion to verify the need for elective Surgery as first recommended by another Physician.

(2) Specifications:

(a) Elective Surgery is covered Surgery that may be deferred and is not an emergency.

(b) Use of a second consultant is at the Participant's option.

(c) If the first recommendation for elective Surgery conflicts with the second consultant's opinion, then a third consultant's opinion is a Covered Service.

(d) The third consultant must be a Physician other than the Physician who first recommended elective Surgery or the Physician who was the second consultant.

2. **Inpatient Medical Services**

Inpatient medical services rendered by a physician or other Professional Provider to a Participant who is receiving Covered Services in a Licensed General Hospital or Skilled Nursing Facility.

Inpatient medical services also include consultation services when rendered to a Participant as an Inpatient of a Licensed General Hospital by another Physician at the request of the attending Physician. Consultation services do not include staff consultations that are required by Licensed General Hospital rules and regulations.

3. **Outpatient Medical Services**

The following Outpatient medical services rendered by a Physician or other Professional Provider to a Participant who is an Outpatient, provided such services are not related to pregnancy, Chiropractic Care, Mental or Nervous Conditions, Alcoholism, Substance Use Disorder or Addiction, except as provided specifically elsewhere in this Summary of Health Care Benefits:

a) **Special Therapy Services**—deep radiation therapy or chemotherapy for a malignancy when such therapy is performed in the Physician's office.

b) **Home and Other Outpatient Services**—medical care for the diagnosis or treatment of an Accidental Injury, Disease, condition or Illness.

c) **Preventive Care Services—**

Benefits are provided for:

(1) Preventive Care Covered Services—See Benefits Outline for complete list. Dietary Counseling, also referred to as "medical nutritional counseling", includes the assessment of a Participant's overall nutritional status followed by the assignment of individualized diet, counseling, and/or specialized nutrition therapies to treat a chronic illness or condition. Dietary Counseling is only covered under the Preventive Care Benefit and includes Dietary Counseling for Diabetes. Dietary Counseling is covered only if provided by a doctor of medicine (M.D.), doctor of osteopathy (D.O.), Registered Dietitian, Physician Assistant (P.A.), or a Nurse Practitioner (N.P.).

(2) Immunizations—see Benefits Outline for complete list.

d) **Physician Office Visit**—Physician office medical visits and consultations, including weight management.

Additional services, such as laboratory, x-ray, and other Diagnostic Services are not included in the Office Visit. Benefits for these services may be available under other areas in this Comprehensive Major Medical Section.

e) **Allergy Injections**
f) **Telehealth Virtual Care Services**

I. Diagnostic Services

Diagnostic Services include mammograms. Tests to determine pregnancy and Pap tests are covered regardless of results. Benefits for Medically Necessary genetic testing are only available when Prior Authorization has been completed and approved by the Contract Administrator.

J. Therapy Services

1. **Radiation Therapy**
2. **Chemotherapy**
3. **Renal Dialysis**

The Maximum Allowance for Renal Dialysis is 125% of the current Medicare allowed amount for In-Network and Out-of-Network Providers, unless a different rate is negotiated with the treating Provider.

4. **Physical Therapy**
   a) Payment is limited to Physical Therapy Services related to Habilitative and Rehabilitative care, with reasonable expectation that the services will produce measurable improvement in the Participant's condition in a reasonable period of time. Physical Therapy Services are covered when performed by:
      (1) A Physician.
      (2) A Licensed Physical Therapist provided the Covered Services are directly related to a written treatment regimen prepared by the Therapist.
      (3) A Podiatrist.
   b) No benefits are provided for:
      (1) The following Physical Therapy Services when the specialized skills of a Licensed Physical Therapist are not required:
         (a) Range of motion and passive exercises that are not related to restoration of a specific loss of function but are useful in maintaining range of motion in paralyzed extremities.
         (b) Assistance in walking, such as that provided in support for feeble or unstable patients.
      (2) Facility-related charges for Outpatient Physical Therapy Services, health club dues or charges, or Physical Therapy Services provided in a health club, fitness facility, or similar setting.
      (3) General exercise programs, even when recommended by a Physician or a Chiropractic Physician, and even when provided by a Licensed Physical Therapist.
      (4) Maintenance, palliative or supportive care.
      (5) Behavioral modification services.
5. **Occupational Therapy**
   a) Payment is limited to Occupational Therapy Services related to Habilitative and Rehabilitative care, with reasonable expectation that the services will produce measurable improvement in the Participant's condition in a reasonable period of time. Occupational Therapy Services are covered when performed by:
      (1) A Physician.
      (2) A Licensed Occupational Therapist provided the Covered Services are directly related to a written treatment regimen prepared by a Licensed Occupational Therapist and approved by a Physician.
   b) No benefits are provided for:
      (1) Facility-related charges for Outpatient Occupational Therapy Services, health club dues or charges, or Occupational Therapy Services provided in a health club, fitness facility, or similar setting.
      (2) General exercise programs, even when recommended by a Physician or a Chiropractic Physician, and even when provided by a Licensed Occupational Therapist.
      (3) Maintenance, palliative or supportive care.
      (4) Behavioral modification services.

6. **Speech Therapy**

Benefits are limited to Speech Therapy Services related to Habilitative and Rehabilitative care, with reasonable expectation that the services will produce measurable improvement in the Participant's condition in a reasonable period of time. Speech Therapy Services are covered when performed by either of the following:

a) A Physician.

b) A Speech Therapist provided the services are directly related to a written treatment regimen designed by the Therapist.

c) No benefits are provided for:

(1) Maintenance or supportive care.

(2) Behavioral modification services.

7. **Growth Hormone Therapy**

8. **Home Intravenous Therapy (Home Infusion Therapy)**

Benefits are limited to medications, services and/or supplies provided to or in the home of the Participant, including but not limited to, hemophilia-related products and services and IVIG products and services that are administered via an intravenous, intraspinal, intra-arterial, intrathecal, subcutaneous, enteral, or intramuscular injection or access device inserted into the body.

9. **Orthoptics (Visual Therapy)**

K. Home Health Skilled Nursing Care Services

The delivery of Skilled Nursing Care services under the direction of a Physician to a Homebound Participant, provided such Provider does not ordinarily reside in the Participant's household or is not related to the Participant by blood or marriage. The services must not constitute Custodial Care. Services must be provided by a Medicare certified Home Health Agency and limited to intermittent Skilled Nursing Care. The patient's Physician must review the care at least every thirty (30) days. No benefits are provided during any period of time in which the Participant is receiving Hospice Covered Services.

L. Hospice Services

1. **Conditions**

A Participant must specifically request Hospice benefits and must meet the following conditions to be eligible:

a) The attending or primary Physician must certify that the Participant is a terminally ill patient with a life expectancy of six (6) months or less.

b) The Participant must live within the Hospice's local geographical area.

c) The Participant must be formally accepted by the Hospice.

d) The Participant must have a designated volunteer Primary Care Giver at all times.

2. **Exclusions and Limitations**

No benefits are provided for:

a) Hospice Services not included in a Hospice Plan of Treatment and not provided or arranged and billed through a Hospice.

b) Continuous Skilled Nursing Care except as specifically provided as a part of Respite Care or Continuous Crisis Care.

c) Hospice benefits provided during any period of time in which a Participant is receiving Home Health Skilled Nursing Care benefits.

M. Chiropractic Care Services

a) Benefits are limited to Chiropractic Care Services related to a significant medical condition necessitating appropriate Medically Necessary evaluation and Neuromusculoskeletal Treatment services. Chiropractic Care Services are covered when:

(1) Services are directly related to a written treatment regimen prepared and performed by a Chiropractic Physician.

(2) Services must be related to recovery or improvement in function, with reasonable expectation that the services will produce measurable improvement in the Participant's condition in a reasonable period of time.

b) No benefits are provided for:

(1) Surgery as defined in this Plan Document and Summary of Health Care Benefits to include injections.
(2) Laboratory and pathology services.
(3) Range of motion and passive exercises that are not related to restoration of a specific loss of function.
(4) Massage therapy, if not performed in conjunction with other modalities or manipulations.
(5) Maintenance, palliative or supportive care.
(6) Preventive or wellness care.
(7) Facility-related charges for Chiropractic Care Services, health club dues or charges, or Chiropractic Care Services provided in a health club, fitness facility, or similar setting.
(8) General exercise programs.
(9) Diagnostic Services, except for x-rays to assist in the diagnosis and Neuromusculoskeletal Treatment plan as defined in this Plan Document and Summary of Health Care Benefits.

N. Durable Medical Equipment

The lesser of the Maximum Allowance or billed charge for rental, (but not to exceed the lesser of the Maximum Allowance or billed charge for the total purchase price) or, at the option of the Contract Administrator, on behalf of the Trust, the purchase of Medically Necessary Durable Medical Equipment required for therapeutic use. The Durable Medical Equipment must be prescribed by an attending Physician or other Professional Provider within the scope of license. Benefits include arch supports, and orthopedic or corrective shoes, limited to one pair or two singles per Participant, per Benefit Period. Benefits need to be rendered by Durable Medical Equipment (DME) Provider. Benefits shall not exceed the cost of the standard, most economical Durable Medical Equipment that is consistent, according to generally accepted medical treatment practices, with the Participant's condition. If the Participant and their Provider have chosen a more expensive treatment than is determined to be the standard and most economical by the Contract Administrator, the excess charge is solely the responsibility of the Participant. Equipment items considered to be common household items are not covered.

Due to ongoing service requirements and safety issues relating to oxygen equipment, this Plan Document and Summary of Health Care Benefits will not limit the cost of oxygen and the rental of oxygen delivery systems to the purchase price of the system(s).

O. Prosthetic Appliances

The purchase, fitting, necessary adjustment, repair, and replacement of Prosthetic Appliances including post-mastectomy prostheses.

Benefits for Prosthetic Appliances are subject to the following limitations:

1. Benefits shall not exceed the cost of the standard, most economical Prosthetic Appliance that is consistent, according to generally accepted medical treatment practices, with the Participant's condition. If the Participant and their Provider have chosen a more expensive treatment than is determined to be the standard and most economical by the Contract Administrator, the excess charge is solely the responsibility of the Participant.
2. No benefits are provided for dental appliances or major Artificial Organs, including but not limited to, artificial hearts and pancreases.
3. Following cataract Surgery, benefits for a required contact lens or a pair of eyeglasses are limited to the first contact lens or pair of eyeglasses, which must be purchased within ninety (90) days.
4. Benefits for required contact lens or a pair of eyeglasses for treatment of Keratoconus.
5. No benefits are provided for the rental or purchase of any synthesized, artificial speech or communications output device or system or any similar device, appliance or computer system designed to provide speech output or to aid an inoperative or unintelligible voice, except for voice boxes to replace all or part of a surgically removed larynx.

P. Orthotic Devices

Orthotic Devices include but are not limited to, Medically Necessary braces, back or special surgical corsets, splints for extremities, and trusses, when prescribed by a Physician, Chiropractic Physician, Podiatrist, Licensed Physical Therapist or Licensed Occupational Therapist. Arch supports, other foot support devices, orthopedic shoes, and garter belts are not considered Orthotic Devices and may be covered under Durable Medical Equipment. Benefits shall not exceed the cost of the standard, most economical Orthotic device that is consistent, according to generally accepted medical treatment practices, with the Participant's condition.

For Participants with Diabetes, when prescribed by a Licensed Provider, Covered Services include therapeutic shoes and inserts. Benefits are limited to the following, per Benefit Period: one (1) pair of custom-molded shoes and inserts, (1) one pair of extra-depth shoes, two (2) additional pairs of inserts for custom-molded shoes, and three (3) pairs of inserts for extra-depth shoes.

Q. Dental Services Related to Accidental Injury

Dental services which are rendered by a Physician or Dentist and required as a result of Accidental Injury to the jaw, Sound Natural Tooth, mouth, or face. Such services are covered only for the twelve (12) month period immediately following the date of injury providing the Plan Document and Summary of Health Care Benefits remains in effect during the twelve (12) month period. Temporomandibular Joint (TMJ) disorder and injuries as a result of chewing or biting are not considered Accidental Injuries, unless the source of the injury is an act of domestic violence. No benefits are available under this section for Orthodontia services.

Benefits are provided for repair of damage to a Sound Natural Tooth, lips, gums, and other portions of the mouth, including fractures of the maxilla or mandible. Repair or replacement of damaged dentures, bridges, or other dental appliances is not covered, unless the appliance must be modified or replaced due to Accidental Injury to a Sound Natural Tooth which are abutting the bridge or denture.

Benefits for dental services related to Accidental Injury under this provision are secondary to dental benefits available to a Participant under another benefit section or available under a dental policy of insurance, contract, or underwriting plan that is separate and distinct from this Plan Document and Summary of Health Care Benefits.

R. Inpatient Rehabilitation or Habilitation Services

Benefits are provided for Inpatient Rehabilitation or Habilitation services subject to the following:

1. Admission for Inpatient Physical Rehabilitation must occur within one hundred twenty (120) days of discharge from an Acute Care Licensed General Hospital.
2. Continuation of benefits is contingent upon approval by the Contract Administrator of a Rehabilitation or Habilitation Plan of Treatment and documented evidence of patient progress submitted to the Contract Administrator at least twice each month.

S. Diabetes Self-Management Education Services

Diabetes Self-Management Education includes instruction in the basic skills of diabetes management through books/educational material as well as an individual or group consultation with a certified diabetes educator, nurse, or dietitian in an American Diabetes Association (ADA) or American Association of Diabetes Educators (AADE) certified program, or other accredited program approved by the Contract Administrator.

T. Post-Mastectomy/Lumpectomy Reconstructive Surgery

Reconstructive Surgery in connection with a Disease related mastectomy/lumpectomy, including:

1. Reconstruction of the breast on which the mastectomy/lumpectomy was performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prostheses and treatment of physical complications at all stages of the mastectomy/lumpectomy, including lymphedemas;

in a manner determined in consultation with the attending Physician and the Participant.

U. Prescribed Contraceptive Services

Covered Services include prescribed devices, injectable, insertable and implantable methods of temporary contraception, such as diaphragms, intrauterine devices (IUDs) and injections. Covered Services include tubal ligation and vasectomy.

There are no benefits for:

1. Over-the-counter items including, but not limited to condoms, spermicides, and sponges.
2. Prescribed contraceptives that could otherwise be purchased over-the-counter.
3. Oral contraceptive prescription drugs and other prescription hormonal contraceptives, such as patches and rings.

V. Breastfeeding Support and Supply Services

The lesser of the Maximum Allowance or billed charge for rental, (but not to exceed the lesser of the Maximum Allowance or billed charge for the total purchase price) or, at the option of the Contract Administrator, the purchase of breastfeeding support and supplies. The breastfeeding support and supplies must be prescribed by an attending Physician or other Professional Provider within the scope of license and must be supplied by a Provider. If the Participant and her Provider have chosen a more expensive item than is determined to be the standard and most economical by the Contract Administrator, the excess charge is solely the responsibility of the Participant. Supply items considered to be personal care items or common household items are not covered.

W. Sleep Study Services

Services rendered, referred, or prescribed by a Physician to diagnose a sleep disturbance or disorder. Services may be performed in a sleep laboratory, monitored by a qualified Sleep Study technician or through a home Sleep Study, via a portable recording device.

X. Approved Clinical Trial Services

Coverage is available for routine patient costs associated with an Approved Clinical Trial. Routine patient costs include but are not limited to Office Visits, diagnostic, laboratory tests and/or other services related to treatment of a medical condition. Routine patient costs are items and services that typically are Covered Services for a Participant not enrolled in an Approved Clinical Trial, but do not include:

1. An Investigational item, device, or service that is the subject of the Approved Clinical Trial;
2. Items and services provided solely to satisfy data collection and analysis needs and not used in the direct clinical management of the Participant; or
3. A service that is clearly inconsistent with widely accepted and established standards of care for the particular diagnosis.

Y. Treatment for Autism Spectrum Disorder

Treatment for Autism Spectrum Disorder, and related diagnoses.

Z. Medical Foods

Medical Foods for inborn errors of metabolism such as Phenylketonuria (PKU) or when a Provider has diagnosed the presence of inadequate nutritional oral intake related to a medical condition or due to a progressive impairment of swallowing or digestion.

AA. Palliative Care Services

A Participant, or a Provider on behalf of the Participant, must specifically request services for Palliative Care. Palliative Care Covered Services are covered when a Provider has assessed that a Participant is in need of Palliative Care for a serious Illness (including remission support), life-limiting injury or end-of-life care, and is limited to the following:

1. Acute Inpatient, Skilled Nursing Facility or Rehabilitation based Palliative Care services.
2. Home Health pain and symptom management services.
3. Home Health psychological and social services including individual and family counseling.
4. Caregiver support rendered by a Provider to a Participant.
5. Advanced care planning limited to face-to-face services between a Provider and a Participant to discuss the Participant's health care wishes if they become unable to make decisions about their care.

AB. Gender Affirming Services

Gender Affirming Covered Services include non-surgical procedures, drugs and treatments. Gender reassignment services may require a documented diagnosis of gender dysphoria (gender identity disorder).

Non-surgical Covered Services include but are not limited to:

a) Hormone therapy for Participants age 25 and older.
b) Puberty suppression therapy for Participants age 25 and older.
c) Electrolysis or laser permeant hair removal may be covered for up to twelve (12) sessions for certain skin graft.

There are no benefits for:

Surgical services including but not limited to Genital Surgery, Breast or chest Surgery (such as augmentation or reduction).

The Contract Administrator does not administer the Prescription Drug benefits. For Prescription Drug benefits, please visit www.SmithRx.com for more information or contact the Plan Sponsor.

VI. Additional Amount of Payment Provisions

Except as specified elsewhere in the Plan, the Contract Administrator will pay benefits for Covered Services after a Participant has satisfied their individual Deductible or, if applicable, the family Deductible has been satisfied:

A. For In-Network Services: Unless stated otherwise, for Covered Services furnished in the state of Idaho, the Contract Administrator will pay or otherwise satisfy a percentage of the Maximum Allowance (shown in the Benefits Outline) if the Covered Services were rendered by a Provider. Several Providers are paid at different rates and/or have different benefit limitations as described in that specific benefit section and in the Benefits Outline.

For Out-of-Network Services: Unless stated otherwise, for Covered Services rendered in the state of Idaho, the Contract Administrator will pay or otherwise satisfy a percentage of the Maximum Allowance (shown in the Benefits Outline) if the Covered Services were rendered by a Provider. Several Providers are paid at different rates and/or have different benefit limitations as described in that specific benefit section and in the Benefits Outline.

B. For Covered Services furnished outside the state of Idaho by a Provider, the Contract Administrator shall provide the benefit payment levels specified in this section according to the following:

1. If the Provider has a PPO agreement for claims payment with the Blue Cross and/or Blue Shield plan in the area where the Covered Services were rendered, the Contract Administrator will base the payment on the local plan's Preferred Provider Organization payment arrangement and allow In-Network benefits. The Provider shall not make an additional charge to a Participant for amounts in excess of the Contract Administrator's payment except for Deductibles, Cost Sharing, Copayments, and noncovered services.
2. If the Provider does not have a PPO agreement for claims payment with the Blue Cross and/or Blue Shield plan in the area where the Covered Services are rendered, the Contract Administrator will base payment on the Maximum Allowance and allow Out-of-Network benefits. Except as provided by the federal No Surprises Act, the Provider is not obligated to accept the Contract Administrator's payment as payment in full. Neither the Contract Administrator nor the Trust are responsible for the difference, if any, between the Contract Administrator's payment and the actual charge.

C. A Contracting Provider rendering Covered Services shall not make an additional charge to a Participant for amounts in excess of the Contract Administrator's payment except for Deductibles, Cost Sharing, Copayments, and noncovered services.

D. Neither the Contract Administrator or the Trust are responsible for the difference, if any, between the Contract Administrator's payment and the actual charge, unless otherwise specified. Except as provided by the federal No Surprises Act, Participants are responsible for any such difference,

including Deductibles, Cost Sharing, Copayments, charges for noncovered services and the amount charged by the Noncontracting Provider that is in excess of the Maximum Allowance.

DEFINITIONS SECTION

For reference, most terms defined in this section are capitalized throughout the Plan. Other terms may be defined where they appear in this Plan Document and Summary of Health Care Benefits**.** Definitions in this Plan Document and Summary of Health Care Benefits shall control over any other definition or interpretation unless the context clearly indicates otherwise.

Accidental Injury—an objectively demonstrable impairment of bodily function or damage to part of the body caused by trauma from a sudden, unforeseen external force or object, occurring at a reasonably identifiable time and place, and without a Participant's foresight or expectation, which requires medical attention at the time of the accident. The force may be the result of the injured party's actions, but must not be intentionally self-inflicted unless caused by a medical condition or domestic violence. Contact with an external object must be unexpected and unintentional, or the results of force must be unexpected and sudden.

Acute Care—Medically Necessary Inpatient treatment in a Licensed General Hospital or other Facility Provider for sustained medical intervention by a Physician and Skilled Nursing Care to safeguard a Participant's life and health. The immediate medical goal of Acute Care is to stabilize the Participant's condition, rather than upgrade or restore a Participant's abilities.

Administrative Services Agreement—a formal agreement between the Contract Administrator and the Board of Trustees outlining responsibilities, general administrative services and benefit payment services.

Admission—begins the first day a Participant becomes a registered Hospital bed patient or a Skilled Nursing Facility patient and continues until the Participant is discharged.

Adverse Benefit Determination—any denial, reduction, rescission of coverage, or termination of, or the failure to provide payment for, a benefit for services or ongoing treatment under the Plan**.**

Advisory Committee on Immunization Practices (ACIP)—a committee consisting of immunization field experts who provide guidance to the Center for Disease Control (CDC) and the Department of Health and Human Services (HHS), on the effective control of vaccine-preventable diseases in the United States. The committee develops written recommendations for the routine administration of vaccines to children and adults; to include dose, route, frequency of administration, precautions and contraindications.

Air Ambulance—medical transport by rotary wing air ambulance or fixed wing air ambulance as those terms are used in Medicare Regulations, including transportation that is certified as either a fixed wing or rotary wing air ambulance and such services and supplies as may be Medically Necessary.

Alcoholism—a behavioral or physical disorder manifested by repeated excessive consumption of alcohol to the extent that it interferes with a Participant's health, social, or economic functioning.

Alcoholism or Substance Use Disorder Treatment—a Provider that is acting under the scope of its license, where required, that is primarily engaged in providing detoxification and Rehabilitative care for Alcoholism, or Substance Use Disorder, or Addiction.

Ambulatory Surgical Facility (Surgery Center)—a Facility Provider that is Medicare Certified and/or otherwise acting under the scope of its license, where required, with a staff of Physicians, which:

1. Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient basis.
2. Provides treatment by or under the supervision of Physicians and provides Skilled Nursing Care while the Participant is in the facility.
3. Does not provide Inpatient accommodations.
4. Is not primarily a facility used as an office or clinic for the private practice of a Physician or other Professional Provider.

Amendment (Amend)—a formal document signed by the Trust. The Amendment adds, deletes or changes the provisions of the Plan and applies to all covered persons, including those persons covered before the Amendment becomes effective, unless otherwise specified.

American Psychiatric Association—an organization composed of medical specialists who work together to ensure effective treatment for all persons with a mental disorder.

American Psychological Association—a scientific and professional organization that represents psychology in the United States.

Applied Behavior Analysis (ABA)—the process of systematically applying interventions based upon the principles of learning theory to make changes to socially significant behavior to a meaningful degree, and to demonstrate the interventions are responsible for the improvement in behavior.

Approved Clinical Trial—a phase I, phase II, phase III, or phase IV clinical trial conducted in relation to prevention, detection, or treatment of cancer or other life-threatening condition.

Artificial Organs—permanently attached or implanted man-made devices that replace all or part of a Diseased or nonfunctioning body organ, including but not limited to, artificial hearts and pancreases.

Autism Spectrum Disorder—means any of the pervasive developmental disorders, autism spectrum disorders, or related diagnoses, as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM).

Autotransplant (or Autograft)—the surgical transfer of an organ or tissue from one (1) location to another within the same individual.

Benefit Period—the specified period of time during which a Participant accumulates annual benefit limits, Deductible amounts and Out-of-Pocket Limits. For the purposes of this document, this period of time is a calendar year from January 1 through December 31.

Benefits Outline—a listing of certain Covered Services specifying Cost Sharing, Copayments, Deductibles, and Benefit limitations and maximums under this Plan Document and Summary of Health Care Benefits.

BlueCard—a program to process claims for most Covered Services received by Participants outside of the Contract Administrator's service area while capturing the local Blue Cross and/or Blue Shield Plan's Provider discounts.

Blue Distinction Centers for Transplants (BDCT)—the BDCT are major hospitals and research institutions located throughout the United States that are designated for Transplants.

Board of Trustees—the Board of Trustees of the Idaho Independent Intergovernmental Authority (III-A) Trust has all discretionary authority to interpret the provisions and control the operation and administration of the Plan within the limits of the law. All decisions made by the Board of Trustees, including final determination of Medical Necessity, shall be final and binding. The Board of Trustees also reserves the right to modify eligibility clauses for new Plan participants who join the Plan as a result of a merger, acquisition or for any employee who was covered under a labor agreement plan during a previous period of employment to which the employee's Employer contributes, provided that coverage under the Plan begins within thirty-one (31) days of the date coverage under the previous Plan terminates. The Idaho Independent Intergovernmental Authority (III-A) Trust may choose to hire a consultant and/or Contract Administrator to perform specified duties in relation to the Plan. The Board of Trustees also has the right to amend, modify or terminate the Plan at any time or in any manner as outlined in the Administrative Services Agreement.

The administration of the Plan document is under the supervision of the Board of Trustees. The Idaho Independent Intergovernmental Authority (III-A) Trust acts on behalf of the Board of Trustees. The Board of Trustees has agreed to indemnify each employee in the Idaho Independent Intergovernmental Authority (III-A) Trust for any liability the employee incurs as a result of acting on behalf of the Board of Trustees, except if such liability is due to the employee's gross negligence or misconduct.

Certified Nurse-Midwife—an individual licensed to practice as a Certified Nurse Midwife.

Certified Registered Nurse Anesthetist—a licensed individual registered as a Certified Registered Nurse Anesthetist.

Chiropractic Care—services rendered, referred, or prescribed by a Chiropractic Physician.

Chiropractic Physician—an individual licensed to practice chiropractic.

Clinical Laboratory Improvement Amendments (CLIA)—a Centers for Medicare & Medicaid Services (CMS) program which regulates all human performed laboratory testing in the United States to ensure quality laboratory testing.

Clinical Nurse Specialist—an individual licensed to practice as a Clinical Nurse Specialist.

Clinical Psychologist—an individual licensed to practice clinical psychology.

Congenital Anomaly—a condition existing at or from birth, which is a significant deviation from the common form or function of the body, whether caused by a hereditary or a developmental defect or Disease. In this Plan Document and Summary of Health Care Benefits, the term significant deviation is defined to be a deviation which impairs the function of the body and includes but is not limited to the conditions of cleft lip, cleft palate, webbed fingers or toes, sixth toes or fingers, or defects of metabolism and other conditions that are medically diagnosed to be Congenital Anomalies.

Continuous Crisis Care—Hospice Nursing Care provided during periods of crisis in order to maintain a terminally ill Participant at home. A period of crisis is one in which the Participant's symptom management demands predominantly Skilled Nursing Care.

Contract Administrator—Blue Cross of Idaho has been hired as the Contract Administrator by the Board of Trustees to perform claims processing and other specified administrative services in relation to this Plan Document and Summary of Health Care Benefits. The Contract Administrator is not an insurer of health benefits under this Plan Document and Summary of Health Care Benefits and does not exercise any of the discretionary authority and responsibility granted to the Board of Trustees. The Contract Administrator is not responsible for Plan financing and does not guarantee the availability of benefits under this Plan Document and Summary of Health Care Benefits.

Contracting Provider—a Provider that has entered into a written agreement with the Contract Administrator regarding payment for Covered Services rendered to a Participant under a PPO program.

Contribution—the amount paid or payable by the Employer or Eligible Employee into the Trust fund.

Copayment—a designated dollar and/or percentage amount, separate from Cost Sharing that a Participant is financially responsible for and must pay to a Provider at the time certain Covered Services are rendered.

Cost Effective—a requested or provided medical service or supply that is Medically Necessary in order to identify or treat a Participant's health condition, illness or injury and that is:

1. Provided in the most cost-appropriate setting consistent with the Participant's clinical condition and the Provider's expertise. For example, when applied to services that can be provided in either an Inpatient hospital setting or Outpatient hospital setting, the Cost Effective setting will generally be the outpatient setting. When applied to services that can be provided in a hospital setting or in a physician office setting, the Cost Effective setting will generally be the physician office setting.
2. Not more costly than an alternative service or supply, including no treatment, and at least as likely to produce an equivalent result for the Participant's condition, Disease, Illness or injury.

Cost Sharing—the percentage of the Maximum Allowance or the actual charge, whichever is less, a Participant is responsible to pay Out-of-Pocket for Covered Services after satisfaction of any applicable Deductibles or Copayments, or both.

Covered Service—when rendered by a Provider, a service, supply, or procedure specified in this Plan Document and Summary of Health Care Benefits for which benefits will be provided to a Participant.

Custodial Care—care designated principally to assist a Participant in engaging in the activities of daily living; or services which constitute personal care, such as help in walking and getting in and out of bed, assistance in eating, dressing, bathing, and using the toilet; preparation of special diets; and supervision of medication, which can usually be self-administered and does not require the continuing attention of trained medical or paramedical personnel. Custodial Care is normally, but not necessarily, provided in a nursing home, convalescent home, rest home, or similar institution.

Deductible—the amount a Participant is responsible to pay Out-of-Pocket before the Contract Administrator begins to pay benefits for most Covered Services. The amount credited to the Deductible is based on the Maximum Allowance or the actual charge, whichever is less.

Dentist—an individual licensed to practice Dentistry.

Dentistry or Dental Treatment—the treatment of teeth and supporting structures, including but not limited to, the replacement of teeth.

Diagnostic Imaging Provider—a person or entity that is licensed, where required, and/or Medicare Certified (and/or otherwise acting under the scope of license) to render Covered Services.

Diagnostic Service—a test or procedure performed on the order of a Physician or other Professional Provider because of specific symptoms, in order to identify a particular condition, Disease, Illness, or Accidental Injury. Diagnostic Services, include but are not limited to:

1. Radiology services.
2. Laboratory and pathology services.
3. Cardiographic, encephalographic, and radioisotope tests.

Disease—any alteration in the body or any of its organs or parts that interrupts or disturbs the performance of vital functions, thereby causing or threatening pain, weakness, or dysfunction. A Disease can exist with or without a Participant's awareness of it, and can be of known or unknown cause(s).

Durable Medical Equipment—items which can withstand repeated use, are primarily used to serve a therapeutic purpose, are generally not useful to a person in the absence of Accidental Injury, Disease or Illness, and are appropriate for use in the Participant's home.

Durable Medical Equipment Supplier—a business that is licensed, where required, and/or Medicare Certified (and/or otherwise acting under the scope of license) to sell or rent Durable Medical Equipment.

Effective Date—the date when coverage for a Participant begins under this Plan Document and Summary of Health Care Benefits.

Electroconvulsive Therapy (ECT)—Electroconvulsive Therapy (ECT) is a treatment for severe forms of depression, bipolar disorder, schizophrenia and other serious mental illnesses that uses electrical impulses to induce a convulsive seizure.

Eligible Dependent—a person eligible for enrollment under an Enrollee's coverage. For the purposes of this Plan Document and Summary of Health Care Benefits, the child of a Surrogate will not be considered an Eligible Dependent of the Surrogate or her spouse.

Eligible Employee—an employee, or partner of a Plan Sponsor, or a retiree who is under the age of sixty-five (65) years, who is entitled to apply as an Enrollee.

Emergency Admission Notification—notification by the Participant to the Contract Administrator of an Emergency Inpatient Admission resulting in an evaluation conducted by the Contract Administrator to determine the Medical Necessity of a Participant's Emergency Inpatient Admission and the accompanying course of treatment.

Emergency Inpatient Admission—Medically Necessary Inpatient admission to a Licensed General Hospital or other Inpatient Facility due to the sudden, acute onset of a medical condition, Mental or Nervous Condition, Substance Use Disorder or Addiction, or an Accidental Injury which requires immediate medical treatment to preserve life or prevent severe, irreparable harm to a Participant.

Emergency Medical Condition—a condition reflected by sudden and unexpected symptoms that are severe enough that a reasonably prudent layperson with average knowledge of health and medicine would expect extreme consequences to result without immediate medical care. These consequences include placing the health of the individual (or, regarding a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. Emergency Medical Conditions, include but are not limited to, heart attacks, cerebrovascular accidents, poisonings, loss of consciousness or respiration, and convulsions, Mental or Nervous Conditions, Substance Use Disorder or Addiction.

Employer—any Employer participating in the Trust.

Enrollee—an Eligible Employee who has enrolled for coverage and has satisfied the requirements of the Eligibility and Enrollment Section.

Family Coverage—the enrollment of an Enrollee and two (2) or more Eligible Dependents under the Plan**.**

Freestanding Diabetes Facility—a person or entity that is recognized by the American Diabetes Association, and/or otherwise acting under the scope of its license, where required, to render Covered Services.

Freestanding Dialysis Facility—a Medicare Certified Facility Provider, or other Facility Provider acting under the scope of its license, that is primarily engaged in providing dialysis treatment, maintenance, or training to patients on an Outpatient or home care basis.

Freestanding Emergency Department—a health care facility that is geographically distinct and licensed separately from a hospital under applicable state law and provides emergency services.

Ground Ambulance—a licensed ground vehicle that is specially designed and equipped for transporting the sick and injured.

Habilitation (or Habilitative)—developing skills and functional abilities necessary for daily living and skills related to communication of persons who have never acquired them.

Health Benefit Plan—any hospital or medical policy or certificate, any subscriber contract provided by a hospital or professional service corporation, or managed care organization subscriber contract. Health Benefit Plan does not include policies or certificates of insurance for specific Disease, hospital confinement indemnity, accident-only, credit, dental, vision, Medicare supplement, long-term care or disability income insurance, student health benefits-only coverage issued as a supplement to liability insurance, Workers' Compensation or similar insurance, automobile medical payment insurance, or nonrenewable short-term coverage issued for a period of twelve (12) months or less.

Homebound—confined primarily to the home as a result of a medical condition. The term connotes that it is "a considerable and taxing effort" to leave the home due to a medical condition and not because of inconvenience.

Home Health Agency—any agency or organization that provides Skilled Nursing Care services and other therapeutic services.

Home Health Aide—an individual employed by a Hospice, under the direct supervision of a licensed registered nurse (R.N.), who performs and trains others to perform, intermittent Custodial Care services which include but are not limited to, assistance in bathing, checking vital signs, and changing dressings.

Home Health Skilled Nursing Care Services—the delivery of Skilled Nursing Care services under the direction of a Physician to a Homebound Participant. Home Health Skilled Nursing is generally intended to transition a Homebound patient from a hospital setting to a home or prevent a hospital stay, provided such nurse does not ordinarily reside in the Participant's household or is not related to the Participant by blood or marriage.

Home Intravenous Therapy Company—a licensed, where required, and/or Medicare Certified (and/or otherwise acting under the scope of its license) pharmacy or other entity that is principally engaged in providing services, medical supplies, and equipment for certain home infusion Therapy Covered Services, to Participants in their homes or other locations outside of a Licensed General Hospital.

Hospice—a Medicare Certified (and/or otherwise acting under the scope of its license, if required) public agency or private organization designated specifically to provide services for care and management of terminally ill patients, primarily in the home.

Hospice Nursing Care—Skilled Nursing Care and Home Health Aide services provided as a part of the Hospice Plan of Treatment.

Hospice Plan of Treatment—a written plan of care that describes the services and supplies for the Medically Necessary care and treatment to be provided to a Participant by a Hospice. The written plan of care must be established and periodically reviewed by the attending Physician.

Hypnosis—an induced passive state in which there is an increased responsiveness to suggestions and commands, provided that these do not conflict seriously with the subject's conscious or unconscious wishes.

Illness—a deviation from the healthy and normal condition of any bodily function or tissue. An Illness can exist with or without a Participant's awareness of it, and can be of known or unknown cause(s).

In-Network Services—Covered Services provided by a Contracting Provider.

Inpatient—a Participant who is admitted as a bed patient in a Licensed General Hospital or other Facility Provider and for whom a room and board charge is made.

Intensive Outpatient Program—Intensive Outpatient Program (IOP) is a treatment program that includes extended periods of therapy sessions, several times a week for a minimum of three (3) hours per day, a minimum of three (3) days per week and a minimum of nine (9) hours per week. It is an intermediate setting between traditional therapy sessions and partial hospitalization.

Investigational—any technology (service, supply, procedure, treatment, drug, device, facility, equipment or biological product), which is in a developmental stage or has not been proven to improve health outcomes such as length of life, quality of life, and functional ability. A technology is considered investigational if, as determined by the Contract Administrator, it fails to meet any <u>one</u> of the following criteria:

- <u>The technology must have final approval from the appropriate government regulatory body.</u> This applies to drugs, biological products, devices, and other products/procedures that must have approval from the U.S. Food and Drug Administration (FDA) or another federal authority before they can be marketed. Interim approval is not sufficient. The condition for which the technology is approved must be the same as that the Contract Administrator is evaluating.
- <u>The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes.</u> The evidence should consist of current published medical literature and investigations published in peer-reviewed journals. The quality of the studies and consistency of results will be considered. The evidence should demonstrate that the technology can measure or alter physiological changes related to a Disease, injury, Illness, or condition. In addition, there should be evidence that such measurement or alteration affects health outcomes.
- <u>The technology must improve the net health outcome.</u> The technology's beneficial effects on health outcomes should outweigh any harmful effects on health outcomes.
- <u>The technology must be as beneficial as any established alternatives.</u>
- <u>The technology must show improvement that is attainable outside the investigational setting.</u> Improvements must be demonstrated when used under the usual conditions of medical practice.

If a technology is determined to be investigational, all services specifically associated with the technology, including but not limited to associated procedures, treatments, supplies, devices, equipment, facilities or drugs will also be considered investigational.

In determining whether a technology is investigational, the Contract Administrator considers the following source documents: Blue Cross Blue Shield Association Center for Clinical Effectiveness (CCE) assessments, the Blue Cross and Blue Shield Association Medical Policy Reference Manual as adopted by the Contract Administrator, and Blue Cross of Idaho Medical Policies. The Contract Administrator also considers current published medical literature and

peer review publications based upon scientific evidence, and evidence-based guidelines developed by national organizations and recognized authorities.

Keratoconus—a developmental or dystrophic deformity of the cornea in which it becomes cone-shaped due to a thinning and stretching of the tissue in its central area.

Licensed General Hospital—a short term, Acute Care, general hospital that:

1. Is an institution licensed in the state in which it is located and is lawfully entitled to operate as a general, Acute Care hospital.
2. Is primarily engaged in providing Inpatient diagnostic and therapeutic services for the diagnosis, treatment, and care of injured and sick persons by or under the supervision of Physicians, for compensation from and on behalf of its patients.
3. Has functioning departments of medicine and Surgery.
4. Provides twenty-four (24) hour nursing service by or under the supervision of licensed R.N.s.
5. Is not predominantly a:
    a. Skilled Nursing Facility
    b. Nursing home
    c. Custodial Care home
    d. Health resort
    e. Spa or sanatorium
    f. Place for rest
    g. Place for the treatment or Rehabilitative care of Mental or Nervous Conditions
    h. Place for the treatment or Rehabilitative care of Alcoholism or Substance Use Disorder or Addiction
    i. Place for Hospice care
    j. Residential Treatment Center
    k. Transitional Living Center

Licensed Marriage and Family Therapist (LMFT)—a licensed individual providing diagnosis and treatment of Mental or Nervous Conditions.

Licensed Pharmacist—an individual licensed to practice pharmacy.

Licensed Rehabilitation Hospital—a Facility Provider principally engaged in providing diagnostic, therapeutic, and Physical Rehabilitation Services to Participants on an Inpatient basis.

Maximum Allowance—for Covered Services under the terms of the Plan, Maximum Allowance is the lesser of the billed charge or the amount established by the Contract Administrator as the highest level of compensation for a Covered Service. If the Covered Services are rendered outside the state of Idaho by a Noncontracting or Contracting Provider with a Blue Cross and/or Blue Shield affiliate in the location of the Covered Services, the Maximum Allowance is the lesser of the billed charge or the amount established by the affiliate as compensation.

The Maximum Allowance is determined using many factors, as applicable, including pre-negotiated payment amounts; diagnostic related groupings (DRGs); a resource based relative value scale (RBRVS); ambulatory payment classifications (APCs); the Provider's charge(s); the charge(s) of Providers with similar training and experience within a particular geographic area; Medicare reimbursement amounts; Qualifying Payment Amount, amount determined under an Independent Dispute Resolution (IDR) in accordance with surprise medical billing requirements under the federal No Surprises Act; and/or the cost of rendering the Covered Service. Moreover, Maximum Allowance may differ depending on whether the Provider is Contracting or Noncontracting.

In addition, Maximum Allowance for Covered Services provided by Contracting or Noncontracting Dentists is determined using many factors, including pre-negotiated payment amounts, a calculation of charges submitted by Contracting Idaho Dentists, and/or a calculation of the average charges submitted by all Idaho Dentists.

Medicaid—Title XIX (Grants to States for Medical Assistance Programs) of the United States Social Security Act as amended.

Medical Food—a food which is formulated to be consumed or administered orally or enterally under the supervision of a Physician.

Medically Necessary (or Medical Necessity)—the Covered Service or supply recommended by the treating Provider to identify or treat a Participant's condition, Disease, Illness or Accidental Injury and which is determined by the Contract Administrator to be:

1. The most appropriate supply or level of service, considering potential benefit and harm to the Participant.
2. Proven to be effective in improving health outcomes:
    a. For new treatment, effectiveness is determined by peer reviewed scientific evidence; or
    b. For existing treatment, effectiveness is determined first by peer reviewed scientific evidence, then by professional standards, then by expert opinion.
3. Not primarily for the convenience of the Participant or Provider.
4. Cost Effective for this condition.

The fact that a Provider may prescribe, order, recommend, or approve a service or supply does not, in and of itself, necessarily establish that such service or supply is Medically Necessary under this Plan Document and Summary of Health Care Benefits.

The term Medically Necessary as defined and used in the Plan is strictly limited to the application and interpretation of the Plan, and any determination of whether a service is Medically Necessary hereunder is made solely for the purpose of determining whether services rendered are Covered Services.

In determining whether a service is Medically Necessary, the Contract Administrator considers the medical records and, the following source documents: Blue Cross Blue Shield Association Center for Clinical Effectiveness (CCE) assessments, the Blue Cross and Blue Shield Association Medical Policy Reference Manual as adopted by the Contract Administrator, and Blue Cross of Idaho Medical Policies. The Contract Administrator also considers current published medical literature and peer review publications based upon scientific evidence, and evidence-based guidelines developed by national organizations and recognized authorities.

Medicare—Title XVIII (Health Insurance for the Aged and Disabled) of the United States Social Security Act as amended.

Medicare Certified—Centers for Medicare and Medicaid Services (CMS) develops standards that health care organizations must meet in order to begin and continue participating in the Medicare and Medicaid programs. These minimum health and safety standards are the foundation for improving quality and protecting the health and safety of beneficiaries.

These standards are the minimum health and safety requirements that providers and suppliers must meet in order to be Medicare and Medicaid Certified.

Mental or Nervous Conditions—means and includes mental disorders, mental Illnesses, psychiatric Illnesses, mental conditions, and psychiatric conditions (whether organic or inorganic, whether of biological, nonbiological, chemical or nonchemical origin and irrespective of cause, basis, or inducement). Mental and Nervous Conditions, include but are not limited to: psychoses, neurotic disorders, schizophrenic disorders, affective disorders, personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems.

Minimum Essential Coverage—the type of coverage an individual needs to have to meet the individual responsibility requirement under the Affordable Care Act. This includes individual market policies, job-based coverage, Medicare, Medicaid, CHIP, TRICARE and certain other coverage.

Morbid Obesity—a condition where an individual's weight is at least 100 pounds over or twice the ideal weight for frame, age, height and sex specified in the 1983 Metropolitan Life Insurance table, or the body mass index (BMI) is over 40 kg/meter squared.

Neuromusculoskeletal Treatment—means and includes diagnosis and treatment in the form of manipulation and adjustment of the vertebrae, disc, spine, back, neck and adjacent tissues in an Outpatient office or clinic setting and for acute or Rehabilitative purposes.

Noncontracting Provider—a Professional Provider or Facility Provider that has not entered into a written agreement with the Contract Administrator regarding payment for Covered Services rendered to a Participant under a PPO program.

Nurse Practitioner—an individual licensed to practice as a Nurse Practitioner.

Occupational Therapist—an individual licensed to practice occupational therapy.

Office Visit—any direct, one-on-one examination and/or exchange, conducted in the Provider's office, between a Participant and a Provider, or members of their staff for the purposes of seeking care and rendering Covered Services. For purposes of this definition, a Medically Necessary visit by a Physician to a Homebound Participant's place of residence may be considered an Office Visit.

Open Enrollment Period—the period of time chosen by the Trust, other than during an Initial Enrollment Period or Special Enrollment Period, in which an Eligible Employee and/or Eligible Dependent may enroll in this Plan Document and Summary of Health Care Benefits, usually once a year.

Optometrist—a person who is licensed and specializes in optometry to examine, measure and treat certain visual defects by means of corrective lenses or other methods that do not require a license as a physician.

Organ Procurement—Diagnostic Services and medical services to evaluate or identify an acceptable donor for a recipient and a donor's surgical and hospital services directly related to the removal of an organ or tissue for such purpose. Transportation for a donor or for a donated organ or tissue is not an Organ Procurement service.

Orthotic Devices—any rigid or semi-rigid supportive devices that restrict or eliminate motion of a weak or Diseased body part.

Out-Of-Network Services—any Covered Services rendered by a Noncontracting Provider.

Out-Of-Pocket Limit—the amount of Out-of-Pocket expenses incurred during one (1) Benefit Period that a Participant is responsible for paying. Eligible Out-of-Pocket expenses include only the Participant's Deductible, Copayments and Cost Sharing for eligible Covered Services.

Outpatient—a Participant who receives services or supplies while not an Inpatient.

Palliative Care—is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening Illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical and psychosocial.

Partial Hospitalization Program—Partial Hospitalization Program (PHP) is a treatment program that provides interdisciplinary medical and psychiatric services. Partial Hospitalization Program (PHP) involves a prescribed course of psychiatric treatment provided on a predetermined and organized schedule and provided in lieu of hospitalization for a patient who does not require full-time hospitalization.

Participant—an Enrollee or an enrolled Eligible Dependent covered under the Plan**.**

Physical Rehabilitation—Medically Necessary non-acute therapy rendered by qualified health care professionals. Physical Rehabilitation is intended to restore a Participant's physical health and well-being as close as reasonably possible to the level that existed immediately prior to the occurrence of a condition, Disease, Illness, or Accidental Injury.

Physical Therapist—an individual licensed to practice physical therapy.

Physician—a doctor of medicine (M.D.) or doctor of osteopathy (D.O.) licensed to practice medicine.

Physician Assistant—an individual licensed to practice as a Physician Assistant.

Plan(s)—a multiple employer welfare plan under which payment for medical, surgical, hospital, and other services for prevention, diagnosis, or treatment of any disease, injury, or bodily condition of an Eligible Employee is, or is to be, regularly provided for or promised from funds created or maintained in whole or in part by Contributions or payments thereto by the Employer and Eligible Employees.

Plan Date—October 1st.

Plan Document and Summary of Health Care Benefits—this description of the benefits provided under the Plan.

Plan Sponsor—a participating Employer in the Trust that performs the applicable responsibilities as outlined in this Plan on behalf of the Trust.

Podiatrist—an individual licensed to practice podiatry.

Post-Service Claim—any claim for a benefit under the Plan that does not require Prior Authorization before services are rendered.

Post-Stabilization Care Services—any additional items and services that are Covered Services after a Participant is stabilized and as part of Outpatient observation or Inpatient or Outpatient stay with respect to the visit in which the emergency services are furnished.

Preadmission Testing—tests and studies required in connection with a Participant's Inpatient admission to a Licensed General Hospital that are rendered or accepted by the Licensed General Hospital on an Outpatient basis. Preadmission tests and studies must be done prior to a scheduled Inpatient admission to the Licensed General Hospital, provided the services would have been available to an Inpatient of that hospital. Preadmission Testing does not include tests or studies performed to establish a diagnosis.

Preferred Blue PPO—a preferred provider organization product offered through the Contract Administrator, on behalf of the Trust.

Prescription Drugs—drugs, biologicals, and compounded prescriptions that are FDA approved and can be dispensed only according to a written prescription given by a Physician and/or duly licensed Provider, that are listed with approval in the *United States Pharmacopeia, National Formulary* or *AMA Drug Evaluations* published by the American Medical Association (AMA), that are prescribed for human consumption, and that are required by law to bear the legend: "Caution—Federal Law prohibits dispensing without prescription."

Pre-Service Claim—any claim for a benefit that requires Prior Authorization before services are rendered.

Primary Care Giver—a person designated to give direct care and emotional support to a Participant as part of a Hospice Plan of Treatment. A Primary Care Giver may be a spouse, relative, or other individual who has personal significance to the Participant. A Primary Care Giver must be a volunteer who does not expect or claim any compensation for services provided to the Participant.

Prior Authorization—the Provider's or the Participant's request to the Contract Administrator, or delegated entity, for a Medical Necessity determination of a Participant's proposed treatment. The Contract Administrator or the delegated entity may review medical records, test results and other sources of information to make the determination. Prior Authorization is not a determination of benefit coverage. Benefit coverage and eligibility for payment is determined solely by the Contract Administrator.

Prosthetic and Orthotic Supplier—a person or entity that is licensed, where required, and Medicare Certified (or otherwise acting under the scope of its license) to render Covered Services.

Prosthetic Appliances—Prosthetic Appliances are devices that replace all or part of an absent body organ, including contiguous tissue, or replace all or part of the function of a permanently inoperative or malfunctioning body organ.

Provider—a person or entity that is licensed, certified, accredited and/or registered, where required, to render Covered Services. Providers include any facility or individual who provides a Covered Service while operating within the scope of their license, certification, accreditation and/or registration under applicable state law, unless exempted by federal law.

Psychiatric Hospital—a Facility Provider principally engaged in providing diagnostic and therapeutic services and Rehabilitation Services for the Inpatient treatment of Mental or Nervous Conditions, Alcoholism or Substance Use Disorder or Addiction. These services are provided by or under the supervision of a staff of Physicians, and continuous nursing services are provided under the supervision of a licensed R.N.

Qualifying Payment Amount—the median contracted rates recognized by the Contract Administrator as the maximum payment for the same or similar Covered Services provided by a Provider in same or similar specialty, in the same geographic area (increased by the consumer price index) in accordance with surprise medical billing requirements under the federal No Surprises Act.

Radiation Therapy Center—a Facility Provider that is primarily engaged in providing Radiation Therapy Services to patients on an Outpatient basis.

Recognized Transplant Center—a Licensed General Hospital that meets any of the following criteria:

1. Is approved by the Medicare program for the requested Transplant Covered Services.
2. Is included in the Blue Cross and Blue Shield System's National Transplant Networks.
3. Has arrangements with another Blue Cross and/or Blue Shield Plan for the delivery of the requested Transplant Covered Services, based on appropriate approval criteria established by that Plan.
4. Is approved by the Contract Administrator based on the recommendation of the Contract Administrator's Medical Director.

Registered Dietitian—a professional trained in foods and the management of diets (dietetics) who is credentialed by the Commission on Dietetic Registration of the American Dietetic Association, or otherwise acting under the scope of their license, where required.

Rehabilitation (or Rehabilitative)—restoring skills and functional abilities necessary for daily living and skills related to communication that have been lost or impaired due to disease, illness or injury.

Rehabilitation or Habilitation Plan of Treatment—a written plan which describes the services and supplies for the Rehabilitation or Habilitation care and treatment to be provided to a Participant. The written plan must be established and periodically reviewed by an attending Physician.

Residential Treatment Center—a Facility Provider licensed by the appropriate state/local authorities as a Residential Treatment Center that is primarily engaged in providing twenty-four (24) hour level of care, including twenty-four (24) hour onsite or on call nursing services and a defined course of therapeutic intervention and special programming in a controlled environment. Care includes treatment with a range of diagnostic and therapeutic behavioral health services that cannot be provided through existing community programs. Residential Treatment Center does not include Custodial Care, outdoor behavioral health programs, half-way houses, supervised living, group homes, boarding houses or other similar facilities providing primarily a supportive and/or recreational environment, even if Mental Health or Substance Use Disorder counseling is provided in such facilities.

Respite Care—care provided to a Homebound Participant as part of a Hospice Plan of Treatment. The purpose of Respite Care is to provide the Primary Care Giver a temporary period of rest from the stress and physical exhaustion involved in caring for the Participant at home.

Skilled Nursing Care—nursing service that must be rendered by or under the direct supervision of a licensed R.N. to maximize the safety of a Participant and to achieve the medically desired result according to the orders and direction of an attending Physician. The following components of Skilled Nursing Care distinguish it from Custodial Care that does not require professional health training:

1. The observation and assessment of the total medical needs of the Participant.
2. The planning, organization, and management of a treatment plan involving multiple services where specialized health care knowledge must be applied in order to attain the desired result.
3. Rendering to the Participant, direct nursing services that require specialized training.

Skilled Nursing Facility—a licensed Facility Provider primarily engaged in providing Inpatient Skilled Nursing Care to patients requiring convalescent care rendered by or under the supervision of a Physician. Other than incidentally, a Skilled Nursing Facility is not a place or facility that provides minimal care, Custodial Care, ambulatory care, or part-time care services; or care or treatment of Mental or Nervous Conditions, Alcoholism, or Substance Use Disorder or Addiction.

Sleep Study—the continuous monitoring of physiological parameters, such as brain and breathing activity of the Participant during sleep.

Sound Natural Tooth—for avulsion or traumatic tooth loss, a Sound Natural Tooth is considered to be one in which the existing conditions of the tooth and its supporting structures did not influence the outcome of the injury in question, is without impairment, including but not limited to periodontal or other conditions, and is not in need of the treatment provided for any reason other than the Accidental Injury.

For injuries related to fracture of the coronal surface, a Sound Natural Tooth is considered to be one which has not been restored by, including but not limited to, a crown, inlay, onlay or porcelain restoration, or treated by endodontics.

Special Care Unit—a designated unit within a Licensed General Hospital that has concentrated facilities, equipment, and support services to provide an intensive level of care for critically ill patients.

Substance Use Disorder or Addiction—a behavioral or physical disorder manifested by repeated excessive use of a drug or alcohol to the extent that it interferes with a Participant's health, social, or economic functioning.

Surgery—within the scope of a Provider's license, the performance of:

1. Generally accepted operative and cutting procedures.
2. Endoscopic examinations and other invasive procedures using specialized instruments.
3. The correction of fractures and dislocations.
4. Customary preoperative and postoperative care.

Surrogate—a woman who agrees to become pregnant and give birth to a child for another individual or couple (the "Intended Parents") in order to give the child to the Intended Parents whether or not the Surrogate is the genetic mother of the child and whether or not the Surrogate does so for compensation.

Telehealth Virtual Care Services—health care services conducted with technology that includes live audio and video communication between the Participant and a Provider in compliance with state and federal laws. No benefits are available for visits conducted by (a) audio-only communication when treatment by such method is not permitted under applicable law at the time of visit, (b) e-mail or (c) fax.

Temporomandibular Joint (TMJ) Syndrome—jaw joint conditions including temporomandibular joint disorders and craniomandibular disorders, and all other conditions of the joint linking the jaw bone and skull and the complex muscles, nerves, and other tissues relating to that joint.

Therapy Services—Therapy Services include only the following:

1. Radiation Therapy—treatment of Disease by x-ray, radium, or radioactive isotopes.
2. Chemotherapy—treatment of malignant Disease by chemical or biological antineoplastic agents.
3. Renal Dialysis—treatment of an acute or chronic kidney condition, which may include the supportive use of an artificial kidney machine.
4. Physical Therapy—treatment by physical means, hydrotherapy, heat or similar modalities, physical agents, biomechanical and neurophysiological principles, or devices to relieve pain, restore maximum function, or prevent disability following a condition, Disease, Illness, Accidental Injury, or loss of a body part.
5. Occupational Therapy—treatment that employs constructive activities designed and adapted for a physically disabled Participant to help satisfactorily accomplish the ordinary tasks of daily living and tasks required by the Participant's particular occupational role.
6. Speech Therapy—corrective treatment of a speech impairment resulting from a condition, Illness, Disease, Surgery, or Accidental Injury; or from Congenital Anomalies, or previous therapeutic processes.

7. Growth Hormone Therapy—treatment administered by intramuscular injection to treat children with growth failure due to pituitary disorder or dysfunction.
8. Home Intravenous Therapy (Home Infusion Therapy)—treatment provided in the home of the Participant or other locations outside of a Licensed General Hospital, that is administered via an intravenous, intraspinal, intra-arterial, intrathecal, subcutaneous, enteral, or intramuscular injection or access device inserted into the body, at or under the direction of a Home Health Agency or other Provider approved by the Contract Administrator.
9. Orthoptics (Visual Therapy)—treatments developing or improving visual skills and abilities; improving visual comfort, ease, and efficiency; and changing visual processing or interpretation of visual information.

Transplant—surgical removal of a donated organ or tissue and the transfer of that organ or tissue to a recipient.

Treatment for Autism Spectrum Disorder—means evidence-based care and related equipment prescribed or ordered for an individual diagnosed with an Autism Spectrum Disorder, or related diagnoses, by a licensed Physician or a licensed psychologist, including but not limited to behavioral health treatment, pharmacy care, psychiatric care, psychological care, and therapeutic care.

Trust—Idaho Independent Intergovernmental Authority (III-A) Trust, also the Board of Trustees.

Trustee—the trustee, whether a single or multiple trustees of the Trust.

EXCLUSIONS AND LIMITATIONS SECTION

In addition to the exclusions and limitations listed elsewhere in this Plan Document and Summary of Health Care Benefits, the following exclusions and limitations apply, unless otherwise specified.

There are no benefits for services, supplies, drugs or other charges that are:

A. Not Medically Necessary. If services requiring Prior Authorization are performed by a Contracting Provider and benefits are denied as not Medically Necessary, the cost of said services are not the financial responsibility of the Participant. However, the Participant could be financially responsible for services found to be not Medically Necessary when provided by a Noncontracting Provider.

B. In excess of the Maximum Allowance.

C. For hospital Inpatient or Outpatient care for extraction of teeth or other dental procedures, unless necessary to treat an Accidental Injury or unless an attending Physician certifies in writing that the Participant has a non-dental, life-endangering condition which makes hospitalization necessary to safeguard the Participant's health and life.

D. Not prescribed by or upon the direction of a Physician or other Professional Provider; or which are furnished by any individuals or facilities other than Licensed General Hospitals, Physicians, and other Providers.

E. Investigational in nature.

F. Provided for any condition, Disease, Illness or Accidental Injury to the extent that the Participant is entitled to benefits under occupational coverage, obtained or provided by or through the Employer under state or federal Workers' Compensation Acts, or under Employer Liability Acts, or other laws providing compensation for work-related injuries or conditions. This exclusion applies whether or not the Participant claims such benefits or compensation, or recovers losses from a third party.

G. Provided or paid for by any federal governmental entity, or unit except when payment under the Plan is expressly required by federal law, or provided or paid for by any state or local governmental entity, or unit where its charges therefore would vary, or are or would be affected, by the existence of coverage under this Plan Document and Summary of Health Care Benefits except as expressly required by state law.

H. Provided for any condition, Accidental Injury, Disease or Illness suffered as a result of any act of war or any war, declared or undeclared.

I. Furnished by a Provider who is related to the Participant by blood or marriage and who ordinarily dwells in the Participant's household.

J. Received from a dental, vision, or medical department maintained by or on behalf of an Employer, a mutual benefit association, labor union, trust or similar person or group.

K. For Surgery intended mainly to improve appearance or for complications arising from Surgery intended mainly to improve appearance, except for:

1. Reconstructive Surgery necessary to treat an Accidental Injury, infection, or other Disease of the involved part; or
2. Reconstructive Surgery to correct Congenital Anomalies in a Participant who is a dependent child.
3. Benefits for reconstructive Surgery to correct an Accidental Injury are available even though the accident occurred while the Participant was covered under a prior insurer's coverage.

L. Rendered prior to the Participant's Effective Date.

M. For personal hygiene, comfort, beautification (including non-surgical services, drugs, and supplies intended to enhance the appearance) even if prescribed by a Physician.

N. For exercise or relaxation items or services even if prescribed by a Physician, including but not limited to, air conditioners, air purifiers, humidifiers, physical fitness equipment or programs, spas, hot tubs, whirlpool baths, waterbeds or swimming pools.

O. For convenience items including but not limited to Durable Medical Equipment such as bath equipment, cold therapy units, duplicate items, home traction devices, or safety equipment.

P. For relaxation or exercise therapies, including but not limited to, educational, art, aroma, dance, sex, sleep, electro sleep, vitamin, chelation, homeopathic, or naturopathic, massage, or music even if prescribed by a Physician.

Q. Recreational therapy or therapeutic recreation programs, which can include, but are not limited to, diabetes camps, adventure therapy, and/or wilderness therapy (which can include, but are not limited to, programs for outdoor behavioral health, childhood diabetes, and childhood cancer).

R. For telephone consultations; and all computer or Internet communications, except as provided by or in connection with Telehealth Virtual Care Services.

S. For failure to keep a scheduled visit or appointment; for completion of a claim form; for interpretation services; or for personal mileage, transportation, food or lodging expenses unless specified as a Covered Service in the Plan, or for mileage, transportation, food or lodging expenses billed by a Physician or other Professional Provider.

T. For Inpatient admissions that are primarily for Diagnostic Services or Therapy Services; or for Inpatient admissions when the Participant is ambulatory and/or confined primarily for bed rest, special diet, behavioral problems, environmental change, or for treatment not requiring continuous bed care.

U. For Inpatient or Outpatient Custodial Care; or for Inpatient or Outpatient services consisting mainly of educational therapy, behavioral modification, self-care or self-help training, except as specified as a Covered Service.

V. For any cosmetic foot care, including but not limited to, treatment of corns, calluses, and toenails (except for surgical care of ingrown or Diseased toenails).

W. Related to Dentistry or Dental Treatment, even if related to a medical condition; or Orthoptics, eyeglasses or contact lenses, or the vision examination for prescribing or fitting eyeglasses or Contact Lenses, unless specified as a Covered Service.

X. For hearing aids, except as specified as a Covered Service.

Y. For any treatment of sexual dysfunction, or sexual inadequacy, including erectile dysfunction and/or impotence, even if related to a medical condition.

Z. Made by a Licensed General Hospital for the Participant's failure to vacate a room on or before the Licensed General Hospital's established discharge hour.

AA. Not directly related to the care and treatment of an actual condition, Illness, Disease or Accidental Injury.

AB. Furnished by a facility that is primarily a nursing home, a convalescent home, or a rest home.

AC. For Acute Care, Rehabilitative care, diagnostic testing except as specified as a Covered Service in the Plan; for Mental or Nervous Conditions and Substance Use Disorder or Addiction services not recognized by the American Psychiatric and American Psychological Associations.

AD. For any of the following:

1. For appliances, splints or restorations necessary to increase vertical tooth dimensions or restore the occlusion, except as specified as a Covered Service;
2. For implants in the jaw; for pain, treatment, or diagnostic testing or evaluation related to the misalignment or discomfort of the temporomandibular joint (jaw hinge), including splinting services and supplies;
3. For alveolectomy or alveoloplasty when related to tooth extraction.

AE. For weight control or treatment of obesity or Morbid Obesity, even if Medically Necessary, including but not limited to Surgery for obesity, except as specifically provided by the Weight Management Program listed as a Covered Service.

AF. For use of operating, cast, examination, or treatment rooms or for equipment located in a Contracting or Noncontracting Provider's office or facility, except for Emergency room facility charges in a Licensed General Hospital, unless specified as a Covered Service.

AG. For the reversal of sterilization procedures, including but not limited to, vasovasostomies or salpingoplasties.

AH. Treatment for reproductive procedures, including but not limited to, ovulation induction procedures and pharmaceuticals, intrauterine insemination, in vitro fertilization, embryo transfer or similar procedures, or procedures that in any way augment or enhance a Participant's reproductive ability, including but not limited to laboratory services, radiology services or similar services related to treatment for reproduction procedures. Any expenses, procedures or services related to Surrogate pregnancy, delivery or donor eggs.

AI. For Transplant services and Artificial Organs, except as specified as a Covered Service.

AJ. For acupuncture.

AK. For surgical procedures that alter the refractive character of the eye, including but not limited to, radial keratotomy, myopic keratomileusis, Laser-In-Situ Keratomileusis (LASIK), and other surgical procedures of the refractive-keratoplasty type, to cure or reduce myopia or astigmatism, even if Medically Necessary, unless specified as a Covered Service in a Vision Benefits Section, if any. Additionally, reversals, revisions, and/or complications of such surgical procedures are excluded, except when required to correct an immediately life-endangering condition.

AL. For Hospice, except as specified as a Covered Service.

AM. For pastoral, spiritual, bereavement or marriage counseling.

AN. For homemaker and housekeeping services or home-delivered meals.

AO. Payment for items or services not permitted under applicable state law or for the treatment of injuries sustained while committing a felony, voluntarily taking part in a riot, or while engaging in an illegal act or occupation, unless such injuries are a result of a medical condition or domestic violence.

AP. For treatment or other health care of any Participant in connection with an Illness, Disease, Accidental Injury or other condition which would otherwise entitle the Participant to Covered Services under this Plan Document and Summary of Health Care Benefits, if and to the extent those benefits are payable to or due the Participant under any medical payments provision, no fault provision, uninsured motorist provision, underinsured motorist provision, or other first party or no fault provision of any automobile, homeowner's, or other similar policy of insurance, contract, or underwriting plan.

AQ. In the event the Contract Administrator for any reason makes payment for or otherwise provides benefits excluded by the above provisions, the Trust shall succeed to the rights of payment or reimbursement of the compensated Provider, the Participant, and the Participant's heirs and personal representative against all insurers, underwriters, self-insurers, or other such obligors contractually liable or obliged to the Participant, or their estate for such services, supplies, drugs or other charges so provided by the Contract Administrator in connection with such Illness, Disease, Accidental Injury or other condition.

AR. For which a Participant would have no legal obligation to pay in the absence of coverage under this Plan Document and Summary of Health Care Benefits or any similar coverage; or for which no charge or a different charge is usually made in the absence of health coverage or insurance coverage or charges in connection with work for compensation or charges; or for which reimbursement or payment is contemplated under an agreement with a third party.

AS. For a routine or periodic mental or physical examination or laboratory test that is not connected with the care and treatment of an actual Illness, Disease or Accidental Injury or for an examination or laboratory test required for any employment-related purpose; or related to an occupational injury; for a marriage license; or for insurance, school or camp application; or for sports participation physicals; or a screening examination including routine hearing examinations, except as specified as a Covered Service.

AT. For immunizations except as specifically provided as a Covered Service.

AU. For nutritional supplements.

AV. For replacements or nutritional formulas except, when administered enterally due to impairment in digestion and absorption of an oral diet and is the sole source of caloric need or nutrition in a Participant, or except as specified as a Covered Service.

AW. For vitamins and minerals, unless required through a written prescription and cannot be purchased over the counter.

AX. For an elective abortion, except to preserve the life of the Participant upon whom the abortion is performed.

AY. For alterations or modifications to a home or vehicle.

AZ. For special clothing, including shoes (unless permanently attached to a brace).

AAA. Provided to a person enrolled as an Eligible Dependent, but who no longer qualifies as an Eligible Dependent due to a change in eligibility status that occurred after enrollment.

AAB. Provided outside the United States, which if had been provided in the United States, would not be a Covered Service.

AAC. For Outpatient pulmonary and/or Outpatient cardiac Rehabilitation, except as specified as a Covered Service in the Plan.

AAD. For complications arising from the acceptance or utilization of services, supplies or procedures that are not a Covered Service.

AAE. For the use of Hypnosis, as anesthesia or other treatment, except as specified as a Covered Service.

AAF. For dental implants, appliances (with the exception of sleep apnea devices), and/or prosthetics, and/or treatment related to Orthodontia, even when Medically Necessary, unless specified as a Covered Service.

AAG. For arch supports, orthopedic shoes, and other foot devices, except as specified as a Covered Service.

AAH. For wigs, except as specified as a Covered Service due to a covered medical condition.

AAI. For surgical removal of excess skin that is the result of weight loss or gain, including but not limited to association with prior weight reduction (obesity) Surgery.

AAJ. For the purchase of Therapy or Service Dogs/Animals and the cost of training/maintaining said animals.

AAK. For procedures including but not limited to breast augmentation, liposuction, Adam's apple reduction, rhinoplasty and facial reconstruction and other procedures considered cosmetic in nature.

AAL. For the treatment of injuries sustained while operating a motor vehicle under the influence of alcohol and/or narcotics. For purposes of this Plan exclusion, "Under the influence" as it relates to alcohol means having a whole blood alcohol content of .08 or above or a serum blood alcohol content of .10 or above as measured by a laboratory approved by the State Police or a laboratory certified by the Centers for Medicare and Medicaid Services. For purposes of this Plan exclusion, "Under the influence" as it relates to narcotics means impairment of driving ability caused by the use of narcotics not prescribed or administered by a Physician.

AAM. Rendered after exhaustion of an established benefit limit, unless authorized at the discretion of the Trust and in accordance with the specific medical criteria established by the Contract Administrator.

AAN. All services, supplies, devices and treatment that are not FDA approved.

AAO. Any services, interventions occurring within the framework of an educational program or institution; or provided in or by a school/educational setting; or provided as a replacement for services that are the responsibility of the educational system.

AAP. All gene and cell therapies that have been approved by the FDA since January 1, 2016, along with gene and cell therapies approved in the future.

AAQ. For any surgical services related to transsexual Surgery and gender transformation.

GENERAL PROVISIONS SECTION

I. Termination or Modification of a Participant's Coverage

A. If an Enrollee ceases to be an Eligible Employee or the Employer does not remit the required Contribution, the Enrollee's coverage and the coverage of any and all enrolled Eligible Dependents will terminate on the last day of the last month for which payment was made. If the Trust does not remit the required payments as required by the Administrative Services Agreement and the Contract Administrator elects to terminate this Agreement, the enrollee's coverage and the coverage of any and all enrolled Eligible Dependents will terminate on the last day for which the Trust reimbursed the Contract Administrator for the payment of claims and administrative fees.

B. Except as provided in this paragraph, coverage for a Participant who is no longer eligible under this Plan Document and Summary of Health Care Benefits will terminate on the date a Participant no longer qualifies as a Participant, as defined in the Eligibility and Enrollment Section. Coverage will not terminate because of age for a Participant who is a dependent child incapable of self-sustaining employment by reason of intellectual disability or physical handicap, who became so incapable prior to reaching the age limit, and who is chiefly dependent on the Enrollee for support and maintenance, provided the Enrollee, within thirty-one (31) days of when the dependent child reaches the age limit, has submitted to the Contract Administrator (at the Enrollee's expense) a Physician's certification of such dependent child's incapacity. The Contract Administrator, on behalf of the Trust, may require, at reasonable intervals during the two (2) years following when the child reaches the age limit, subsequent proof of the child's continuing disability and dependency. After two (2) years, the Contract Administrator, on behalf of the Trust, may require such subsequent proof once each year. Coverage for the dependent child will continue so long as the Plan remains in effect, the child's disability and financial dependency exists, and the child has not exhausted benefits.

C. Termination or modification of this Plan Document and Summary of Health Care Benefits automatically terminates or modifies all of the Participant's coverage and rights hereunder. It is the responsibility of the Employer to notify all of its Participants of the termination or any modification of this Plan Document and Summary of Health Care Benefits, and the Contract Administrator's notice to the Trust, upon mailing or any other delivery, constitutes complete and conclusive notice to the Participants.

D. No benefits are available to a Participant for Covered Services rendered after the date of termination of a Participant's coverage.

E. The Trust may terminate or retroactively rescind a Participant's coverage under this Plan Document and Summary of Health Care Benefits for any intentional misrepresentation, omission, or concealment of fact by, concerning, or on behalf of any Participant that was or would have been material to the Trust's acceptance of a risk, extension of coverage, provision of benefits, or payment of any claim.

F. Prior to legal finalization of an adoption, the coverage provided in this Plan Document and Summary of Health Care Benefits for a child placed for adoption with an Enrollee continues as it would for a naturally born child of the Enrollee until the first of the following events occurs:

1. The date the child is removed permanently from placement and the legal obligation terminates, or
2. The date the Enrollee rescinds, in writing, the agreement of adoption or the agreement assuming financial responsibility.

If one (1) of the foregoing events occurs, coverage terminates on the last day of the month in which such event occurs.

G. Coverage under this Plan Document and Summary of Health Care Benefits will terminate for an Eligible Dependent on the last day of the month the Participant no longer qualifies as an Eligible Dependent due to a change in eligibility status.

II. Trust—COBRA

The Contract Administrator is not the plan administrator for compliance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and any amendments to it. Except for services the Contract Administrator has agreed to perform regarding COBRA, the Plan Sponsor is responsible for satisfaction of notice, disclosure, and other obligations if these laws are applicable to the Employer.

III. Contract Between the Contract Administrator and the Trust—Description of Coverage

This Plan Document and Summary of Health Care Benefits is part of the Administrative Services Agreement between the Contract Administrator and the Trust. The Contract Administrator will provide the Trust with copies of the Plan to give to each Enrollee as a description of coverage or provide electronic access to the Plan Document and Summary of Health Care Benefits, but this Plan Document and Summary of Health Care Benefits shall not be construed as a contract between the Contract Administrator and any Enrollee. The Contract Administrator's mailing or any electronic delivery of the Plan to the Trust constitutes complete and conclusive issuance and delivery thereof to each Enrollee.

IV. Benefits to Which Participants are Entitled

A. Subject to all of the terms of this Plan Document and Summary of Health Care Benefits, a Participant is entitled to benefits for Covered Services in the amounts specified in the benefit sections and/or in the Benefits Outline.

B. Benefits will be provided only if Covered Services are prescribed by, or performed by, or under the direction of a Physician or other Professional Provider and are regularly and customarily included in such Providers' charges.

C. Covered Services are subject to the availability of Licensed General Hospitals and other Facility Providers and the ability of the employees of such Providers and of available Physicians to provide such services. The Trust and/or the Contract Administrator shall not assume nor have any liability for conditions beyond its control which affect the Participant's ability to obtain Covered Services.

D. The Trust intends the Plan to be permanent, but because future conditions affecting the Trust cannot be anticipated or foreseen, the Trust reserves the right to amend, modify, or terminate the Plan at any time, which may result in the termination or modification of the Participants' Coverage. Expenses incurred prior to the Plan modification or termination will be paid as provided under the terms of the Plan prior to its modification or termination. Any material change made to the Plan will be provided in writing within sixty (60) days of the Effective Date of change.

V. Notice of Claim

The Contract Administrator will process claims for benefits on behalf of the Trust according to the Administrative Services Agreement between the parties. A claim for Covered Services must be submitted within one year from the date of service and must include all the information necessary for the Contract Administrator to determine benefits.

VI. Release and Disclosure of Medical Records and Other Information

In order to effectively apply the provisions of the Plan, the Contract Administrator may obtain information from Providers and other entities pertaining to any health related services that the Participant may receive or may have received in the past. The Contract Administrator may also disclose to Providers and other entities, information obtained from the Participant's transactions, Contributions, payment history and claims data necessary to allow the processing of a claim and for other health care operations. To protect the Participant's privacy, the Contract Administrator treats all information in a confidential manner.

VII. Exclusion of General Damages

Liability under this Plan Document and Summary of Health Care Benefits for benefits conferred hereunder, including recovery under any claim or breach of the Plan, shall be limited to the actual benefits for Covered

Services as provided herein and shall specifically exclude any claim for general damages, including but not limited to, alleged pain, suffering or mental anguish, or for economic loss, or consequential loss or damages.

VIII. Payment of Benefits

The Contract Administrator provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

A. The Contract Administrator, on behalf of the Trust, is authorized by the Participant to make payments directly to Providers rendering Covered Services to the Participant for benefits provided under the Plan. Notwithstanding this authorization, the Contract Administrator, on behalf of the Trust, reserves and shall have the right to make such payments directly to the Participant. Except as provided by law, the Contract Administrator's right, on behalf of the Trust, to pay a Participant directly is not assignable by a Participant nor can it be waived without the Contract Administrator's concurrence, on behalf of the Trust, nor may the right to receive benefits for Covered Services under this Plan Document and Summary of Health Care Benefits be transferred or assigned, either before or after Covered Services are rendered. Payments will also be made in accordance with any assignment of rights required by state Medicaid plan.

B. The Contract Administrator and the Trust prohibit direct or indirect payment by third parties unless it meets the standards set below.

Family, friends, religious institutions, private, not-for-profit foundations such as Indian tribes, tribal organizations, urban Indian organizations, state and federal government programs or grantees or sub-grantees such as the Ryan White HIV/AIDS Program and other similar entities are not prohibited from paying Contribution on behalf of an individual receiving medical treatment. Cost Sharing Contributions made from permitted third parties will be applied to the Participants applicable Deductible and/or Out-of-Pocket Limit.

Each of the following criteria must be met for the Contract Administrator or the Trust to accept a third party payment:

1. the assistance is provided on the basis of the Participant's financial need;
2. the institution/organization is not a healthcare Provider; and
3. the institution/organization is not financially interested. Financially interested institutions/organizations include institutions/organizations that receive the majority of their funding from entities with a pecuniary interest in the payment of health insurance claims, or institutions/organizations that are subject to direct or indirect control of entities with a pecuniary interest in the payment of health insurance claims.

To assist in appropriately applying Cost Sharing contributions made from a permitted third party to the Participants applicable Deductible and/or Out-of-Pocket Limit, the Participant is encouraged to provide notification to the Contract Administrator if they receive any form of assistance for payment of their Contribution, Cost Sharing, Copayment or Deductible amounts.

Contributions submitted in violation of this provision will not be accepted and the Enrollee's Plan may be terminated for non-payment. Cost Sharing contributions made from non-permitted third parties will not be applied to the Participants applicable Deductible and/or Out-of-Pocket Limit. The Contract Administrator will inform the Participant in writing of the reason for rejecting or otherwise refusing to treat a third party payment as a payment from the Participant.

C. Once Covered Services are rendered by a Provider, the Contract Administrator, on behalf of the Trust, shall not be obliged to honor Participant requests not to pay claims submitted by such Provider, and the Contract Administrator, on behalf of the Trust, shall have no liability to any person because of its rejection of such request; however, in its sole discretion, for good cause, the Contract Administrator, on behalf of the Trust, may nonetheless deny all or any part of any Provider claim.

IX. Participant/Provider Relationship

A. The choice of a Provider is solely the Participant's.

B. The Contract Administrator does not render Covered Services but only makes payment for Covered Services received by Participants. The Contract Administrator and the Trust are not liable for any act or omission or for the level of competence of any Provider, and have no responsibility for a Provider's failure or refusal to render Covered Services to a Participant.

C. The use or nonuse of an adjective such as Contracting or Noncontracting is not a statement as to the ability of the Provider.

X. Participating Plan

the Contract Administrator may, in its sole discretion, make an agreement with any appropriate entity (referred to as a Participating Plan) to provide, in whole or in part, benefits for Covered Services to Participants, but it shall have no obligation to do so.

XI. Coordination of the Plan's Benefits with Other Benefits

This Coordination of Benefits (COB) provision applies when a Participant has health care coverage under more than one (1) Contract. Contract is defined below.

The Order of Benefit Determination Rules govern the order in which each Contract will pay a claim for benefits. The Contract that pays first is called the Primary Contract. The Primary Contract must pay benefits in accordance with its terms without regard to the possibility that another Contract may cover some expenses. The Contract that pays after the Primary Contract is the Secondary Contract. The Secondary Contract may reduce the benefits it pays so that payments from all Contracts does not exceed one hundred percent (100%) of the total Allowable Expenses.

A. Definitions

1. A Contract is any of the following that provides benefits or services for medical or dental care or treatment. If separate Contracts are used to provide coordinated coverage for members of a group, the separate Contracts are considered parts of the same Contract and there is no COB among those separate contracts.
   a) Contract includes: group and non-group insurance contracts, health maintenance organization (HMO) contracts, Closed Panel Plans or other forms of group or group type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

   b) Contract does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefit for non-medical components of long-term care policies; Medicare supplement policies; Medicare or any other federal governmental plans, unless permitted by law.

   Each Contract for coverage under a) or b) is a separate Contract. If a Contract has two (2) parts and COB rules apply only to one (1) of the two (2), each of the parts is treated as a separate Contract.

2. This Contract means, in a COB provision, the part of the Contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other Contracts. Any other part of the Contract providing health care benefits is separate from this plan. A Contract may apply one (1) COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, any may apply under COB provision to coordinate other benefits.

3. The Order of Benefit Determination Rules determine whether This Contract is a Primary Contract or Secondary Contract when the Participant has health care coverage under more than one (1) Contract. When This Contract is primary, it determines payment for its benefits first before those of any other Contract without considering any other Contract's benefits.

When This Contract is secondary, it determines its benefits after those of another Contract and may reduce the benefits it pays so that all Contract benefits do not exceed one hundred percent (100%) of the total Allowable Expense.

4. Allowable Expense is a health care expense, including Deductibles, Cost Sharing and Copayments, that is covered at least in part by any Contract covering the Participant. When a Contract provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Contract covering the Participant is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an Allowable Expense.

   The following are examples of expenses that are not Allowable Expenses:

   a) The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable Expense, unless one of the Contracts provides coverage for private hospital room expenses.

   b) If a Participant is covered by two (2) or more Contracts that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology, or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.

   c) If a Participant is covered by two (2) or more Contracts that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees it not an Allowable Expense.

   d) If a Participant is covered by one (1) Contract that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Contract that provides its benefits or services on the basis of negotiated fees, the Primary Contract's payment arrangement shall be the Allowable Expense for all Contracts. However, if the provider has contracted with the Secondary Contract to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Contract's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Contract to determine its benefits.

   e) The amount of any benefit reduction by the Primary Contract because a covered person has failed to comply with the Contract provisions is not an Allowable Expense. Examples of these types of Contract provisions include second surgical opinions, pre-certificate of admissions, and preferred provider arrangements.

5. Closed Panel Plan is a Contract that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

6. Custodial Parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

B. Order of Benefit Determination Rules

When a Participant is covered by two (2) or more Contracts, the rules for determining the order of benefit payments are as follows:

1. The Primary Contract pays or provides its benefits according to its terms of coverage and without regard to the benefits of any other Contract.

2. a) Except as provided in Paragraph 2.b) below, a Contract that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Contracts state that the complying Contract is primary.

   b) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Contract provided by the Contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.

3. A Contract may consider the benefits paid or provided by another Contract in calculating payment of its benefits only when it is secondary to that other Contract.

4. Each Contract determines its order of benefits using the first of the following rules that apply:
   a) Non-Dependent or Dependent. The Contract that covers the Participant other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Contract and the Contract that covers the Participant as a dependent is the Secondary Contract. However, if the Participant is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Contract covering the Participant as a dependent; and primary to the Contract covering the Participant as other than a dependent (e.g. a retired employee); then the order of benefits between the two Contracts is reversed so that the Contract covering the Participant as an employee, member, policyholder, subscriber or retiree is the Secondary Contract and the other Contract is the Primary Contract.

   b) Dependent Child Covered Under More Than One Contract. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Contract the order of benefits is determined as follows:
      (1) For a dependent child whose parents are married or are living together, whether or not they have ever been married: The Contract of the parent whose birthday falls earlier in the calendar year is the Primary Contract; or if both parents have the same birthday, the Contract that has covered the parent the longest is the Primary Contract.
      (2) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
         i. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Contract of that parent has actual knowledge of those terms, that Contract is primary. This rule applies to Contract year commencing after the Contract is given notice of the court decree;
         ii. If a court decree states that both parents are responsible for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (1) shall determine the order of benefits;
         iii. If a court decree states both parents have joint custody without specifying that one parent has responsibility for the health care

expenses or health care coverage, the provisions of Subparagraph (1) above shall determine the order of benefits;

iv. If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

1. The Contract covering the Custodial Parent;
2. The Contract covering the spouse of the Custodial Parent;
3. The Contract covering the non-Custodial Parent; and then
4. The Contract covering the spouse of the non-Custodial Parent.

For a dependent child covered under more than one Contract of individuals who are not the parents of the child, the provisions of Subparagraph (1) or (2) above shall determine the order of benefits as if those individuals were the parents of the child.

c) Active Employee or Retired or Laid-off Employee. The Contract that covers a Participant as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Contract. The Contract covering that same Participant as a retired or laid-off employee is the Secondary Contract. The same would hold true if a Participant is a dependent of an active employee and that same Participant is a dependent of a retired or laid-off employee. If the other Contract does not have this rule, and as a result, the Contracts do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled 4.a) can determine the order of benefits.

d) COBRA or State Continuation Coverage. If a Participant whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Contract, the Contract covering the Participant as an employee, member, subscriber or retiree or covering the Participant as a dependent of an employee, member, subscriber or retiree is the Primary Contract and the COBRA or state or other federal continuation coverage is the Secondary Contract. If the other Contract does not have this rule, and as a result, the Contracts do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled 4.a) can determine the order of benefits.

e) Longer or Shorter Length of Coverage. The Contract that covered the Participant as an employee, member, policyholder, subscriber, or retiree longer is the Primary Contract and the Contract that covered the Participant the shorter period of time is the Secondary Contract.

f) If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Contracts meeting the definition of Contract. In addition, This Contract will not pay more than it would have paid had it been the Primary Contract.

C. Effect on the Benefits of this Contract

1. When This Contract is secondary, it may reduce its benefits so that the total benefits paid or provided by all Contracts during a Contract year are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Contract will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under its Contract that is unpaid by the Primary Contract. The Secondary Contract may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Contract, the total benefits paid or provided by all Contracts for the claim do not exceed the total Allowable Expenses for that claim. In addition, the Secondary Contract shall credit to its Contract deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

2. If a covered person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Contract and other Closed Panel Plans.

D. Facility of Payment

A payment made under another Contract may include an amount that should have been paid under this Contract. If it does, the Contract Administrator may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this Contract. The Contract Administrator will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

E. Right of Recovery

If the amount of the payments made by the Contract Administrator is more than it should have paid under this COB provision, it may recover the excess from one or more of the Participants it has paid or for whom it has paid; or any other Participant or organization that may be responsible for the benefits or services provided for the covered Participant. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

XII. Benefits for Medicare Eligibles Who are Covered Under the Plan

A. If anyone Employer in the Plan has twenty (20) or more employees Participants who become or remain a Participant of the Employer covered by this Plan Document and Summary of Health Care Benefits after becoming eligible for Medicare (due to reaching age sixty-five (65)) are entitled to receive the benefits of this Plan Document and Summary of Health Care Benefits as primary. For an exception to be available to this provision, the Employer must affirmatively opt out of the MSP rules by submitting the documentation required by the CMS Medicare Secondary Payer (MSP) Manual to the Contract Administrator for each Employer seeking to opt-out of MSP rules.

B. If anyone Employer in the Plan has one hundred (100) or more employees, the Plan is considered a large group health plan and Participants of the Employer covered by this Plan Document and Summary of Health Care Benefits after becoming eligible for Medicare due to disability are entitled to receive the benefits of this Plan Document and Summary of Health Care Benefits as primary.

C. A Participant eligible for Medicare based solely on end stage renal Disease is entitled to receive the benefits of the Plan as primary for eighteen (18) months only, beginning with the month of Medicare entitlement, if Medicare entitlement is effective before March 1, 1996. If Medicare entitlement is effective on or after March 1, 1996, the Participant is entitled to receive the benefits of the Plan as primary for thirty (30) months only, beginning with the month of Medicare entitlement. Medicare is secondary during the thirty (30) month period, known as the coordination period. When the Plan is primary, it pays in accordance with the terms of the Plan. In certain circumstances, such as when using a Noncontracting Provider, Participants may be responsible for amounts in excess of the Maximum Allowance. Medicare does not typically permit billing for amounts in excess of the Maximum Allowance, when it is primary. Participants should contact Medicare for more information about their options.

D. The Trust's retirees, if covered under this Plan Document and Summary of Health Care Benefits, and Eligible Employees or spouses of Eligible Employees (if a Participant) who are not subject to paragraphs A., B. or C. of this provision and who are Medicare eligible due to disability, will receive the benefits of the Plan reduced by any benefits available under Medicare. This applies even if the Participant fails to enroll in Medicare or does not claim the benefits available under Medicare.

XIII. Incorporated by Reference

All of the terms, limitations and exclusions of coverage contained in this Plan Document and Summary of Health Care Benefits are incorporated by reference into all sections, endorsements, riders, and Amendments and are as effective as if fully expressed in each one unless specifically noted to the contrary.

XIV. Inquiry and Appeals Procedures

If the Participant's claim for benefits is denied and an Adverse Benefit Determination is issued, the Participant must first exhaust any applicable internal appeals process described below prior to pursuing legal action.

A. Informal Inquiry

For any initial questions concerning a claim, a Participant should call or write the Contract Administrator's Customer Service Department. The Contract Administrator's phone numbers and addresses are listed on the Explanation of Benefits (EOB) form and in the Contact Information section of this Plan Document and Summary of Health Care Benefits.

B. Formal Appeal

A Participant who wishes to formally appeal a Pre-Service Claim decision may do so through the following process:

1. A Participant may have an authorized representative pursue a benefit claim or an appeal of an Adverse Benefit Determination on their behalf. The Trust requires that a Participant execute an "Appointment of Authorized Representative" form before the Contract Administrator, on behalf of the Trust determines that an individual has been authorized to act on behalf of the Participant. The form can be found on the Contract Administrator's Website at www.bcidaho.com.

2. A written appeal must be sent to the Appeals and Grievance Coordinator within one hundred eighty (180) days after receipt of the notice of Adverse Benefit Determination. Urgent claim appeals, and the documents in support of such appeals may be submitted by phone or facsimile. The appeal should set forth the reasons why the Participant contends the decision was incorrect. Any written comments, documents or other relevant information may be submitted with the appeal.

3. After receipt of the appeal, all facts, including those originally used in making the initial decision and any additional information that is sent or that is otherwise relevant, will be reviewed by the Contract Administrator's Medical Director or physician designee. For non-urgent claim appeals, the Contract Administrator will mail a written reply to the Participant within fifteen (15) days after receipt of the written appeal. Urgent claim appeals will be notified orally within seventy-two (72) hours. If the original decision is upheld, the reply will state the specific reasons for denial and the specific provisions on which the decision is based. Each appeal will be processed as quickly as possible taking into account the medical exigencies of each claim.

4. Furthermore, the Participant or their authorized representative has the right to reasonable access to, and copies of all documents, records, and other information that are relevant to the appeal.

5. If the original, non-urgent claim decision is upheld upon reconsideration, the Participant may send an additional written appeal to the Appeals and Grievance Coordinator requesting further review. This appeal must set forth the reasons for requesting additional reconsideration and must be sent within thirty (30) days of the Contract Administrator's mailing of the initial reconsideration decision. The Contract Administrator Medical Director who is not subordinate to the Medical Director or physician designee who decided the initial appeal, will issue a final decision after consideration of all relevant information. A final decision on the appeal will be made within fifteen (15) days of its receipt.

C.

A Participant who wishes to formally appeal a Post-Service Claims decision may do so through the following process:

1. A Participant may have an authorized representative pursue a benefit claim or an appeal of an Adverse Benefit Determination on their behalf. The Trust requires that a Participant execute an "Appointment of Authorized Representative" form before the Contract Administrator, on behalf of the Trust determines that an individual has been authorized to act on behalf of the Participant. The form can be found on the Contract Administrator's Website at www.bcidaho.com.

2. A written appeal must be sent to the Appeals and Grievance Coordinator within one hundred eighty (180) days after receipt of the notice of Adverse Benefit Determination. This written appeal should set forth the reasons why the Participant contends the decision was incorrect. Any written comments, documents or other relevant information may be submitted with the appeal.

3. After receipt of the written appeal, all facts, including those originally used in making the initial decision and any additional information that is sent or that is otherwise relevant, will be reviewed by the Contract Administrator Medical Director, or physician designee if the appeal requires medical judgment. The Contract Administrator shall mail a written reply to the Participant within thirty (30) days after receipt of the written appeal. If the original decision is upheld, the reply will list the specific reasons for denial and the specific provisions on which the decision is based. Each appeal will be processed as quickly as possible.

4. Furthermore, the Participant or their authorized representative has the right to reasonable access to, and copies of all documents, records, and other information that are relevant to the appeal.

5. If the original decision is upheld upon reconsideration, the Participant may send an additional written appeal to the Appeals and Grievance Coordinator requesting *further review*. This appeal must set forth the reasons for requesting additional reconsideration and must be sent within sixty (60) days of the Contract Administrator's mailing of the initial reconsideration decision. A Medical Director of the Contract Administrator who is not subordinate to the Medical Director or physician designee who decided the initial appeal, will issue a final decision after consideration of all relevant information, if the appeal requires medical judgment. A final decision on the appeal will be made within thirty (30) days of its receipt. If the appeal does not require medical judgment, a Vice President of the Contract Administrator who did not decide the initial appeal will issue the decision.

D. Participant's Rights to an Independent External Review

Please read this carefully. It describes a procedure for review of a disputed health claim by a qualified professional who has no affiliation with the Trust or the Contract Administrator. If a Participant or their authorized representative requests an independent external review of a claim, the decision made by the independent reviewer will be binding and final on the Trust.

If the Contract Administrator, on behalf of the Trust, issues a final Adverse Benefit Determination of a Participant's request to provide or pay for a health care service or supply, a Participant may have the right to have the Contract Administrator's decision reviewed by health care professionals who have no association with the Contract Administrator. A Participant has this right only if the Contract Administrator's denial decision involved:

- The Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a Participant's health care service or supply, or
- Determination that a Participant's health care service or supply was Investigational.

A Participant must first exhaust the internal grievance and appeal processes described in this Plan Document and Summary of Health Care Benefits. Exhaustion of that process includes completing all levels of appeal. Exhaustion of the appeals process is not required if the Contract Administrator failed to respond to a standard appeal within thirty-five (35) days in writing or to an urgent appeal within three business days of the date the Participant filed the appeal, unless the Participant requested or agreed to a delay. The Contract Administrator may also agree to waive the exhaustion requirement for an external review request. The Participant may file for an internal urgent appeal with the Contract Administrator and for an expedited external review with the Idaho Department of Insurance at the same time if the Participant's request qualifies as an "urgent care request" defined below.

A Participant may submit a written request for an external review to:

Idaho Department of Insurance
ATTN: External Review
700 W State St, 3rd Floor
Boise ID 83720-0043

For more information and for an external review request form:

- See the department's Website, www.doi.idaho.gov, or
- Call the department's telephone number, (208) 334-4250, or toll-free in Idaho, 1-800-721-3272.

A Participant may act as their own representative in a request or a Participant may name another person, including a Participant's treating health care provider, to act as an authorized representative for a request. If a Participant wants someone else to represent them, a Participant must include a signed "Appointment of an Authorized Representative" form with the request before the Contract Administrator, on behalf of the Trust, determines that an individual has been authorized to act on behalf of the Participant. The form can be found on the Contract Administrator's Website www.bcidaho.com. A Participant's written external review request to the Idaho Department of Insurance must include a completed form authorizing the release of any medical records the independent review organization may require to reach a decision on the external review. The department will not act on an external review request without a Participant's completed authorization form. If the request qualifies for external review, the Contract Administrator's final Adverse Benefit Determination will be reviewed by an independent review organization selected by the Department of Insurance. The Trust will pay the costs of the review.

Standard External Review Request: A Participant must file a written external review request with the Department of Insurance within four (4) months after the date the Contract Administrator issues a final notice of denial.

1. Within seven (7) days after the Department of Insurance receives the request, the Department of Insurance will send a copy to the Contract Administrator.
2. Within fourteen (14) days after the Contract Administrator receives the request from the Department of Insurance, we will review the request for eligibility. Within five (5) business days after the Contract Administrator completes that review, we will notify the Participant and the Department of Insurance in writing if the request is eligible or what additional information is needed. If the Contract Administrator denies the eligibility for review, the Participant may appeal that determination to the Department.
3. If the request is eligible for review, the Department of Insurance will assign an independent review organization to your review within seven (7) days of receipt of the Contract Administrator's notice. The Idaho Department of Insurance will also notify the Participant in writing.
4. Within seven (7) days of the date you receive the Idaho Department of Insurance's notice of assignment to an independent review organization, the Participant may submit any additional information in writing to the independent review organization that they want the organization to consider in its review.
5. The independent review organization must provide written notice of its decision to the Participant, the Contract Administrator and to the Department of Insurance within forty-two (42) days after receipt of an external review request.

Expedited External Review Request: A Participant may file a written "urgent care request" with the Idaho Department of Insurance for an expedited external review of a pre-service or concurrent service denial. The Participant may file for an internal urgent appeal with the Contract Administrator and for an expedited external review with the Idaho Department of Insurance at the same time.

"Urgent care request" means a claim relating to an admission, availability of care, continued stay or health care service for which the covered person received emergency services but has not been discharged from a facility, or any Pre-Service Claim or concurrent care claim for medical care or

treatment for which application of the time periods for making a regular external review determination:

1. Could seriously jeopardize the life or health of the Participant or the ability of the Participant to regain maximum function;
2. In the opinion of the Provider with knowledge of the covered person's medical condition, would subject the Participant to severe pain that cannot be adequately managed without the disputed care or treatment; or
3. The treatment would be significantly less effective if not promptly initiated.

The Idaho Department of Insurance will send your request to us. The Contract Administrator will determine, no later than the second (2^{nd}) full business day, if the request is eligible for review. The Contract Administrator's decision if the request is eligible. If the Contract Administrator denies the eligibility for review, the Participant may appeal that determination to the Department of Insurance.

If the request is eligible for review, the Idaho Department of Insurance will assign an independent review organization to the review upon receipt of the Contract Administrator's notice. The Idaho Department of Insurance will also notify the Participant. The independent review organization must provide notice of its decision to the Participant, the Contract Administrator and to the Idaho Department of Insurance within seventy-two (72) hours after the date of receipt of the external review request. The independent review organization must provide written confirmation of its decision within forty-eight (48) hours of notice of its decision. If the decision reverses the Contract Administrator's denial, the Contract Administrator will notify the Participant and the Department of Insurance of the Contract Administrator's intent to pay for the covered benefit as soon as reasonably practicable, but not later than one (1) business day after receiving notice of the decision.

Binding Nature of the External Review Decision:
The external review decision by the independent review organization will be final and binding on both the Plan and the Participant. **This means that if the Participant elects to request external review, the Participant will be bound by the decision of the independent review organization. The Participant will not have any further opportunity for review of the Contract Administrator's denial after the independent review organization issues its final decision.** If the Participant chooses not to use the external review process, other options for resolving a disputed claim may include mediation, arbitration or filing an action in court.

Under Idaho law, the independent review organization is immune from any claim relating to its opinion rendered or acts or omissions performed within the scope of its duties unless performed in bad faith or involving gross negligence.

XV. Reimbursement of Benefits Paid by Mistake

If the Contract Administrator mistakenly makes payment for benefits on behalf of an Enrollee or their Eligible Dependent(s) that the Enrollee or their Eligible Dependent(s) is not entitled to under this Plan Document and Summary of Health Care Benefits, the Enrollee must reimburse the erroneous payment to the Contract Administrator, on behalf of the Trust.

The reimbursement is due and payable as soon as the Contract Administrator notifies the Enrollee and requests reimbursement. The Contract Administrator, on behalf of the Trust, may also recover such erroneous payment from any other person or Provider to whom the payments were made. If reimbursement is not made in a timely manner, the Contract Administrator, on behalf of the Trust, may reduce benefits or reduce an allowance for benefits as a set-off toward reimbursement.

Even though the Contract Administrator, on behalf of the Trust, may elect to continue to provide benefits after mistakenly paying benefits, the Contract Administrator, on behalf of the Trust, may still enforce this provision. This provision is in addition to, not instead of, any other remedy the Contract Administrator, on behalf of the Trust, may have at law or in equity.

XVI. Subrogation and Reimbursement Rights

Please contact your manager of employee benefits for additional subrogation services not provided by the Contract Administrator.

The benefits of this Plan Document and Summary of Health Care Benefits will be available to a Participant when the Participant is injured, suffers harm or incurs loss due to any act, omission, or defective or unreasonably hazardous product or service of another person, firm, corporation or entity (hereinafter referred to as "third party"). To the extent that such benefits for Covered Services are provided or paid for by the Contract Administrator, on behalf of the Trust under this Plan Document and Summary of Health Care Benefits, agreement, certificate, contract or plan, the Contract Administrator, on behalf of the Trust shall be subrogated and succeed to the rights of the Participant or, in the event of the Participant's death, to the rights of their heirs, estate, and/or personal representative.

As a condition of receiving benefits for Covered Services in such an event, the Participant or their personal representative shall furnish the Contract Administrator in writing with the names, addresses, and contact information of the third party or parties that caused or are responsible, or may have caused or may be responsible for such injury, harm or loss, and all facts and information known to the Participant or their personal representative concerning the injury, harm or loss. In addition, the Participant shall furnish the name and contact information of the liability insurer and its adjuster of the third party, including the policy number, of any liability insurance that covers, or may cover, such injury, harm, or loss.

The Contract Administrator, on behalf of the Trust may at its option elect to enforce either or both of its rights of subrogation and reimbursement.

Subrogation is taking over the Participant's right to receive payments from other parties. The Participant or their legal representative will transfer to the Contract Administrator, on behalf of the Trust any rights the Participant may have to take legal action arising from the injury, harm or loss to recover any sums paid on behalf of the Participant. Thus, the Contract Administrator, on behalf of the Trust may initiate litigation at its sole discretion, in the name of the Participant, against any third party or parties. Furthermore, the Participant shall fully cooperate with the Contract Administrator in its investigation, evaluation, litigation and/or collection efforts in connection with the injury, harm or loss and shall do nothing whatsoever to prejudice the Contract Administrator's subrogation rights and efforts. The Contract Administrator, on behalf of the Trust, will be reimbursed in full for all benefits paid even if the Participant is not made whole or fully compensated by the recovery. Moreover, the Contract Administrator and the Trust are not responsible for any attorney's fees, other expenses or costs incurred by the Participant without the prior written consent of the Contract Administrator and, therefore, the "common fund" doctrine does not apply to any amounts recovered by any attorney the Participant hires regardless of whether amounts recovered are used to repay benefits paid by the Contract Administrator, on behalf of the Trust.

Additionally, the Contract Administrator, on behalf of the Trust, may at its option elect to enforce its right of reimbursement from the Participant, or their legal representative, of any benefits paid from monies recovered as a result of the injury, harm or loss. The Participant shall fully cooperate with the Contract Administrator, on behalf of the Trust, in its investigation, evaluation, litigation and/or collection efforts in connection with the injury, harm or loss and shall do nothing whatsoever to prejudice the Plans reimbursement rights and efforts.

The Participant shall pay the Contract Administrator, on behalf of the Trust, as the first priority, and the Contract Administrator shall have a constructive trust and an equitable lien on, all amounts from any recovery by suit, settlement or otherwise from any third party or parties or from any third party's or parties' insurer(s), indemnitor(s) or underwriter(s), to the extent of benefits provided by the Contract Administrator, on behalf of the Trust under this Plan Document and Summary of Health Care Benefits, regardless of how the recovery is allocated *(i. e.*, pain and suffering) and whether the recovery makes the Participant whole. Thus, the Contract Administrator will be reimbursed by the Participant, or their legal representative, from monies recovered as a result of the injury, harm or loss, for all benefits paid even if the Participant is not made whole or fully compensated by the recovery. Moreover, the Contract Administrator and the Trust are not responsible for any attorney's fees, other expenses or costs incurred by the Participant without the prior written consent of the Contract Administrator and, therefore, the "common fund" doctrine does not apply to any amounts recovered by any attorney the Participant hires regardless of whether amounts recovered are used to repay benefits paid by the Contract Administrator, on behalf of the Trust.

To the extent that the Contract Administrator, on behalf of the Trust, provides or pays benefits for Covered Services, the Contract Administrator's rights of subrogation and reimbursement extend to any right the

Participant has to recover from the Participant's insurer, or under the Participant's "Medical Payments" coverage or any "Uninsured Motorist," "Underinsured Motorist," or other similar coverage provisions, and workers' compensation benefits.

The Contract Administrator, on behalf of the Trust shall have the right, at its option, to seek reimbursement from, or enforce its right of subrogation against, the Participant, the Participant's personal representative, a special needs trust, or any trust, person or vehicle that holds any payment or recovery from or on behalf of the Participant including the Participant's attorney.

The Contract Administrator's subrogation and reimbursement rights shall take priority over the Participant's rights both for benefits provided and payments made by the Contract Administrator, and for benefits to be provided or payments to be made by the Contract Administrator in the future on account of the injury, harm or loss giving rise to the Contract Administrator's subrogation and reimbursement rights. Further, the Plan's subrogation and reimbursement rights for such benefits and payments provided or to be provided are primary and take precedence over the rights of the Participant, even if there are deficiencies in any recovery or insufficient financial resources available to the third party or parties to totally satisfy all of the claims and judgments of the Participant and the Contract Administrator.

Collections or recoveries made by a Participant for such injury, harm or loss in excess of such benefits provided and payments made shall first be allocated to such future benefits and payments that would otherwise be owed by the Plan on account of the injury, harm or loss giving rise to the Contract Administrator's subrogation and reimbursement rights, and shall constitute a Special Credit applicable to such future benefits and payments that would otherwise be owed by the Plan, or any subsequent group health plan provided by the Plan Sponsor. Thereafter, the Contract Administrator, on behalf of the Trust, shall have no obligation to provide any further benefits or make any further payments until the Participant has incurred medical expenses in treatment of such injury, harm or loss equal to such Special Credit.

XVII. Statements

In the absence of fraud, all statements made by an applicant, or the planholder, or by an enrolled person shall be deemed representations and not warranties, and no statement made for the purpose of acquiring coverage under the Plan shall void such coverage under the Plan Document and Summary of Health Care Benefits or reduce benefits unless contained in a written instrument signed by the Plan Sponsor or the enrolled person.

XVIII. Out-of-Area Services

Overview

The Contract Administrator has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Arrangements." These Inter-Plan Arrangements operate under rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever Participants access healthcare services outside the geographic area served by the Contract Administrator, the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described generally below.

Typically, when accessing care outside the geographic area served by the Contract Administrator, Participants obtain care from healthcare Providers that have a contractual agreement ("participating Providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, Participants may obtain care from healthcare Providers in the Host Blue geographic area that do not have a contractual agreement ("nonparticipating Providers") with the Host Blue. The Contract Administrator remains responsible for fulfilling its contractual obligations to you. The Contract Administrator payment practices in both instances are described below.

This disclosure describes how claims are administered for Inter-Plan Arrangements and the fees that are charged in connection with Inter-Plan Arrangements. Note that Dental Care Benefits, except when not paid as medical claims/benefits, and those Prescription Drug Benefits or Vision Care Benefits that may be administered by a third party contracted by the Contract Administrator to provide the specific service or services are not processed through Inter-Plan Arrangements.

A. BlueCard® Program

The BlueCard® Program is an Inter-Plan Arrangement. Under this Arrangement, when Participants access Covered Services within the geographic area served by a Host Blue/outside the geographic area served by the Contract Administrator, the Host Blue will be responsible for contracting and handling all interactions with its participating healthcare Providers. The financial terms of the BlueCard Program are described generally below.

1. Liability Calculation Method Per Claim – In General

a. Participant Liability Calculation

Unless subject to a fixed dollar copayment, the calculation of the Participant liability on claims for Covered Services will be based on the lower of the participating Provider's billed charges for Covered Services or the negotiated price made available to the Contract Administrator by the Host Blue.

b. The Trust Liability Calculation

The calculation of the Trust liability on claims for Covered Services processed through the BlueCard Program will be based on the negotiated price made available to the Contract Administrator by the Host Blue under the contract between the Host Blue and the Provider. Sometimes, this negotiated price may be greater for a given service or services than the billed charge in accordance with how the Host Blue has negotiated with its participating healthcare Provider(s) for specific healthcare services. In cases where the negotiated price exceeds the billed charge, the Trust may be liable for the excess amount even when the Participant's deductible has not been satisfied. This excess amount reflects an amount that may be necessary to secure (a) the Provider's participation in the network and/or (b) the overall discount negotiated by the Host Blue. In such a case, the entire contracted price is paid to the Provider, even when the contracted price is greater than the billed charge.

2. Claims Pricing

Host Blues determine a negotiated price, which is reflected in the terms of each Host Blue's Provider contracts. The negotiated price made available to the Contract Administrator by the Host Blue may be represented by one of the following:

(i) An actual price. An actual price is a negotiated rate of payment in effect at the time a claim is processed without any other increases or decreases; or

(ii) An estimated price. An estimated price is a negotiated rate of payment in effect at the time a claim is processed, reduced or increased by a percentage to take into account certain payments negotiated with the Provider and other claim- and non-claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, Provider refunds not applied on a claim-specific basis, retrospective settlements and performance-related bonuses or incentives; or

(iii) An average price. An average price is a percentage of billed charges for Covered Services in effect at the time a claim is processed representing the aggregate payments negotiated by the Host Blue with all of its healthcare Providers or a similar classification of its Providers and other claim- and non-claim-related transactions. Such transactions may include the same ones as noted above for an estimated price.

The Host Blue determines whether it will use an actual, estimated or average price. The use of estimated or average pricing may result in a difference (positive or negative) between the price the Trust pays on a specific claim and the actual amount the Host Blue pays to the Provider. However, the BlueCard Program requires that the amount paid by the Participant and the Trust is a final price; no future price adjustment will result in increases or decreases to the pricing of past claims.

Any positive or negative differences in estimated or average pricing are accounted for through variance accounts maintained by the Host Blue and are incorporated into future claim prices. As a result, the amounts charged to the Trust will be adjusted in a following year, as necessary, to account for over- or underestimation of the past years' prices. The Host Blue will not receive compensation from how the estimated price or average price

methods, described above, are calculated. Because all amounts paid are final, neither positive variance account amounts (funds available to be paid in the following year), nor negative variance amounts (the funds needed to be received in the following year), are due to or from the Trust. If the Trust terminates, you will not receive a refund or charge from the variance account.

Variance account balances are small amounts relative to the overall paid claims amounts and will be liquidated/drawn down over time. The timeframe for their liquidation depends on variables, including, but not limited to, overall volume/number of claims processed and variance account balance. Variance account balances may earn interest at the federal funds or similar rate. Host Blues may retain interest earned on funds held in variance accounts.

3. BlueCard Program Fees and Compensation

The Trust understands and agrees to reimburse the Contract Administrator for certain fees and compensation which the Contract Administrator are obligated under the BlueCard Program to pay to the Host Blues, to the Association and/or to vendors of BlueCard Program-related services. The specific BlueCard Program fees and compensation that are charged to the Trust are set forth in Appendix A. BlueCard Program Fees and compensation may be revised from time to time as described in section G. below.

B. Special Cases: Value-Based Programs

Value-Based Programs Overview

The Plan Sponsor's Participants may access Covered Services from Providers that participate in a Host Blue's Value-Based Program. Value-Based Programs may be delivered either through the BlueCard Program or a Negotiated Arrangement. These Value-Based Programs may include, but are not limited to, Accountable Care Organizations, Global Payment/Total Cost of Care arrangements, Patient Centered Medical Homes and Shared Savings arrangements.

Value-Based Programs under the BlueCard Program

Value-Based Programs Administration

Under Value-Based Programs, a Host Blue may pay Providers for reaching agreed-upon cost/quality goals in the following ways:

The Host Blue may pass these Provider payments to the Contract Administrator, which the Contract Administrator will pass directly on to the Plan Sponsor as either an amount included in the price of the claim, or an amount charged separately in addition to the claim.

When such amounts are included in the price of the claim, the claim may be billed using one of the following pricing methods, as determined by the Host Blue:

(i) Actual Pricing: The charge to accounts for Value-Based Programs incentives/Shared Savings settlements is part of the claim. These charges are passed to the Plan Sponsor via an enhanced Provider fee schedule.

(ii) Supplemental Factor: The charge to accounts for Value-Based Programs incentives/Shared Savings settlements is a supplemental amount that is included in the claim as an amount based on a specified supplemental factor (e.g., a small percentage increase in the claim amount). The supplemental factor may be adjusted from time to time.

When such amounts are billed separately from the price of the claim, they may be billed as follows:

- Per Member Per Month (PMPM) Billings: Per Member Per Month billings for Value-Based Programs incentives/Shared Savings settlements to accounts are outside of the claim system. The Contract Administrator will pass these Host Blue charges directly through to the Plan Sponsor as a separately identified amount on the group billings.

The amounts used to calculate either the supplemental factors for estimated pricing or PMPM billings are fixed amounts that are estimated to be necessary to finance the cost of a particular Value-Based Program. Because amounts are estimates, there may be positive or negative differences based on actual experience, and such differences will be accounted for in a variance account maintained by the Host Blue (in the same manner as described in the BlueCard claim pricing section above) until the

end of the applicable Value-Based Program payment and/or reconciliation measurement period. The amounts needed to fund a Value-Based Program may be changed before the end of the measurement period if it is determined that amounts being collected are projected to exceed the amount necessary to fund the program or if they are projected to be insufficient to fund the program.

At the end of the Value-Based Program payment and/or reconciliation measurement period for these arrangements, Host Blues will take one of the following actions:

- Use any surplus in funds in the variance account to fund Value-Based Program payments or reconciliation amounts in the next measurement period.
- Address any deficit in funds in the variance account through an adjustment to the PMPM billing amount or the reconciliation billing amount for the next measurement period.

The Host Blue will not receive compensation resulting from how estimated, average or PMPM price methods, described above, are calculated. If the Plan Sponsor terminates, you will not receive a refund or charge from the variance account. This is because any resulting surpluses or deficits would be eventually exhausted through prospective adjustment to the settlement billings in the case of Value-Based Programs. The measurement period for determining these surpluses or deficits may differ from the term of the Plan.

Variance account balances are small amounts relative to the overall paid claims amounts and will be liquidated/drawn down over time. The timeframe for their liquidation depends on variables, including, but not limited to, overall volume/number of claims processed and variance account balance. Variance account balances may earn interest, and interest is earned at the federal funds or similar rate. Host Blues may retain interest earned on funds held in variance accounts.

Note: Participants will not bear any portion of the cost of Value-Based Programs except when a Host Blue uses either average pricing or actual pricing to pay Providers under Value-Based Programs.

Care Coordinator Fees

Host Blues may also bill the Contract Administrator for Care Coordinator Fees for Provider services which we will pass on to the Plan Sponsor as follows:

1. PMPM billings; or
2. Individual claim billings through applicable care coordination codes from the most current editions of either Current Procedural Terminology (CPT) published by the American Medical Association (AMA) or Healthcare Common Procedure Coding System (HCPCS) published by the U.S. Centers for Medicare and Medicaid Services (CMS).

As part of the Plan, the Contract Administrator and the Plan Sponsor will not impose Participant Cost Sharing for Care Coordinator Fees.

Value-Based Programs under Negotiated Arrangements

If the Contract Administrator has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to the Plan Sponsor's Participants, the Contract Administrator will follow the same procedures for Value-Based Programs administration and Care Coordination Fees as noted in the BlueCard Program section.

Exception: For negotiated arrangements, when Control/Home Licensees have negotiated with accounts to waive member Cost Sharing for care coordinator fees, the following provision will apply: As part of the Plan, the Contract Administrator and the Plan Sponsor have agreed to waive Participant Cost Sharing for care coordinator fees.

C. Prepayment Review and Return of Overpayments

If a Host Blue conducts prepayment review activities including, but not limited to, data mining, itemized bill reviews, secondary claim code editing, and DRG audits, the Host Blue may bill the Contract Administrator up to a maximum of 16 percent of the savings identified, unless an alternative reimbursement arrangement is agreed upon by the Contract Administrator and the Host Blue, and these fees may be charged to the Plan Sponsor. If a Host Blue engages a third party to perform these

activities on its behalf, the Host Blue may bill the Contract Administrator the lesser of the full amount of the third-party fees or up to sixteen percent (16%) of the savings identified, unless an alternative reimbursement arrangement is agreed upon by the Contract Administrator and the Host Blue, and these fees may be charged to the Plan Sponsor.

Recoveries from a Host Blue or its participating and nonparticipating Providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, audits/healthcare Provider/hospital bill audits, credit balance audits, utilization review refunds and unsolicited refunds. Recoveries will be applied so that corrections will be made, in general, on either a claim-by-claim or prospective basis. If recovery amounts are passed on a claim-by-claim basis from a Host Blue to the Contract Administrator, they will be credited to the Trust's account. In some cases, the Host Blue will engage a third party to assist in identification or collection of recovery amounts. The fees of such a third party may be charged to the Trust as a percentage of the recovery.

Unless otherwise agreed to by the Host Blue, for retroactive cancellations of membership, the Contract Administrator will request the Host Blue to provide full refunds from participating healthcare Providers for a period of only one year after the date of the Inter-Plan financial settlement process for the original claim. For Care Coordinator Fees associated with Value-Based Programs, the Contract Administrator will request such refunds for a period of only up to ninety (90) days from the termination notice transaction on the payment innovations delivery platform. In some cases, recovery of claim payments associated with a retroactive cancellation may not be possible if, as an example, the recovery (a) conflicts with the Host Blue's state law or healthcare Provider contracts, (b) would result from Shared Savings and/or Provider Incentive arrangements or (c) would jeopardize the Host Blue's relationship with its participating healthcare Providers, notwithstanding to the contrary any other provision of the Plan.

D. Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

In some instances, federal or state laws or regulations may impose a surcharge, tax or other fee that applies to self-funded accounts. If applicable, the Contract Administrator will disclose any such surcharge, tax or other fee to the Trust, which will be the Trust liability.

E. Nonparticipating Providers Outside the Contract Administrator Service Area

Please refer to the Additional Amount of Payment Provisions section in this Plan Document and Summary of Health Care Benefits.

F. Blue Cross Blue Shield Global Core

1. General Information

If Participants are outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands (hereinafter: "BlueCard service area"), they may be able to take advantage of BCBS Global Core when accessing Covered Services. BCBS Global Core is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although BCBS Global Core assists Participants with accessing a network of Inpatient, outpatient and professional Providers, the network is not served by a Host Blue. As such, when Participants receive care from Providers outside the BlueCard service area, the Participants will typically have to pay the Providers and submit the claims themselves to obtain reimbursement for these services.

- **Inpatient Services**
  In most cases, if Participants contact the BCBS Global Core Service Center for assistance, hospitals will not require Participants to pay for covered Inpatient services, except for their deductibles, Cost Sharing, etc. In such cases, the hospital will submit Participant claims to the BCBS Global Core service center to initiate claims processing. However, if the Participant paid in full at the time of service, the Participant must submit a claim to obtain reimbursement for Covered Services. **Participants must contact Blue Cross of Idaho to obtain precertification for non-emergency Inpatient services.**
- **Outpatient Services**
  Physicians, urgent care centers and other outpatient Providers located outside the BlueCard service area will typically require Participants to pay in full at the time of service.

Participants must submit a claim to obtain reimbursement for Covered Services.

- **Submitting a BCBS Global Core Claim**
  When Participants pay for Covered Services outside the BlueCard service area, they must submit a claim to obtain reimbursement. For institutional and professional claims, Participants should complete a BCBS Global Core claim form and send the claim form with the Provider's itemized bill(s) to the BCBS Global Core service center address on the form to initiate claims processing. The claim form is available from Blue Cross of Idaho, the BCBS Global Core service center, or online at www.bcbsglobalcore.com. If Participants need assistance with their claim submissions, they should call the BCBS Global Core service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.

2. BCBS Global Core-Related Fees

The Trust understands and agrees to reimburse Blue Cross of Idaho for certain fees and compensation which we are obligated under applicable Inter-Plan Arrangement requirements to pay to the Host Blues, to the Association and/or to vendors of Inter-Plan Arrangement-related services. The specific fees and compensation that are charged to the Trust under BCBS Global Core are set forth in Appendix A. Fees and compensation under applicable Inter-Plan Arrangements may be revised from time to time as provided for in section G. below.

G. Modifications or Changes to Inter-Plan Arrangement Fees or Compensation

Modifications or changes to Inter-Plan Arrangement fees are generally made effective Jan. 1 of the calendar year, but they may occur at any time during the year. In the case of any such modifications or changes, the Contract Administrator shall provide the Trust with at least thirty (30) days' advance written notice of any modification or change to such Inter-Plan Arrangement fees or compensation describing the change and the effective date thereof and the Trust right to terminate this Agreement without penalty by giving written notice of termination before the effective date of the change. If the Trust fails to respond to the notice and does not terminate this Agreement during the notice period, the Trust will be deemed to have approved the proposed changes, and the Contract Administrator will then allow such modifications to become part of this Agreement.

XIX. Individual Benefits Management

Individual Benefits Management allows the Contract Administrator to provide alternative benefits in place of specified Covered Services when alternative benefits allow the Participant to achieve optimum health care in the most cost-effective way.

The decision to allow alternative benefits will be made by the Contract Administrator, on behalf of the Trust, in its sole and absolute discretion on a case-by-case basis. The Contract Administrator may allow alternative benefits in place of specified Covered Services when a Participant, or the Participant's legal guardian and their Physician concur in the request for and the advisability of alternative benefits. The Contract Administrator reserves the right to modify, limit, or cease providing alternative benefits at any time.

A determination to cover alternative benefits for a Participant shall not be deemed to waive, alter, or affect the Contract Administrator's right to reject any other requests or recommendations for alternative benefits.

XX. Coverage and Benefits Determination

On behalf of the Trust, the Contract Administrator is vested with authority and discretion to determine eligibility for coverage and whether a claim for benefits is covered under the terms of this Plan Document and Summary of Health Care Benefits, based on all the terms and provisions set forth in this Plan Document and Summary of Health Care Benefits, and also to determine the amount of benefits owed on claims which are covered.

XXI. Health Care Providers Outside the United States

The benefits available under the Plan are also available to Participants traveling or living outside the United States. The Inpatient Notification and Prior Authorization requirements will apply. If the Provider is a Contracting Provider with BlueCard, the Contracting Provider will submit claims for reimbursement on behalf of the Participant. Reimbursement for Covered Services will be made directly to the Contracting Provider. If the Health Care Provider does not participate with BlueCard, the Participant will be responsible for payment of

services and submitting a claim for reimbursement to the Contract Administrator. The Contract Administrator will require the original claim along with an English translation. It is the Participant's responsibility to provide this information.

Finally, there are no benefits for services, supplies, drugs or other charges that are provided outside the United States, which if had been provided in the United States, would not be a Covered Service under this Plan Document and Summary of Health Care Benefits.

RIGHTS OF PLAN PARTICIPANTS

As a participant in the Idaho Independent Intergovernmental Authority (III-A) Trust Employee Benefit Plan, you are entitled to certain rights under federal law.

According to the law, you have the right to examine, without charge at the Trust's office or other specific locations, all documents and contracts of the Plan that are filed with the U.S. Department of Labor, such as detailed annual reports and Plan Contracts. You may obtain copies of all documents upon written request to the Trust. The Trust may make a reasonable charge for the copies. You are also entitled to receive a summary of the Plan's annual financial report.

If your claim for benefits under the Plan is denied in whole or in part, you will receive a written explanation of the reason for the denial. If you do not agree with the denial, you have the right to ask the Trust to review the claim. If you are not satisfied with the result of such a review, you may file suit in a state or federal court.

Federal law imposes duties on the individuals responsible for the operation of the Plan to do so carefully and in the interest of all participants. No one, including your Trust, a union, or any other person, may fire you or discriminate against you to prevent you from obtaining any benefit under the Plan or exercising your rights under federal law.

Under federal law, there are steps you can take to enforce your rights. For instance, if you request materials from the Trust and do not receive them within thirty (30) days, you may file suit in a federal court. The court may require the Trust to provide the materials and pay you up to $110 a day until you receive the materials unless the delay is beyond the control of the Trust. If the people who operate the Plan misuse the Plan's money, or if you are discriminated against for enforcing your rights you may seek assistance from the U.S. Department of Labor or file suit in a federal court. If you do file suit, the court will decide who should pay court costs and legal fees. If your case is upheld by the court, the court may order the person or organization you have sued to pay related expenses. If you lose or the court finds your case frivolous, you may be ordered to pay the court costs and legal fees.

If you have a question about this statement or about your rights under HIPAA, or other applicable law, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, Seattle District Office, 1111 Third Avenue, Suite 815, MIDCOM Tower, Seattle, Washington 98101-3212, Phone: 206-553-7700 or as listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor 200 Constitution Avenue, NW, Washington, D.C. 20210.

GENERAL INFORMATION

Name and Address of the Trust

Idaho Independent Intergovernmental Authority (III-A) Trust
PO Box 190477
Boise, ID 83719
(208) 317-2814

Name and Address of the Contract Administrator

Blue Cross of Idaho
3000 E. Pine Avenue
Meridian, ID 83642-5995
PO Box 7408
Boise, ID 83707
(208) 345-4550

Name and Address of the Designated Agent for Service of Legal Process

Jeremy Chou
Givens Pursley LLP
601 W Bannock Street
Boise, ID 83702

Internal Revenue Service and Plan Identification Number

The corporate tax identification number assigned by the Internal Revenue Service is 45-1341997 the Plan number is 501.

Plan Year

The Plan Year is the 12-month fiscal period for the Plan beginning October 1, which is used for the purpose of IRS tax filing.

Method of Funding Benefits

Benefits are self-funded from the Trust and Employer Contributions.

Payments out of the Plan to health care providers on behalf of the covered person will be based on the provisions of the Plan.