2024 PLAN DOCUMENT AND BOOKLET FOR

BOISE FIRE & POLICE TRUST

ERHC Plan

Group Number: 10017672

Medical Benefits

Plan Sponsors: Boise Firefighters International Association of Fire Fighters Local 149 and Boise Police International Brotherhood of Police Officers Local 486

This is a self-funded Plan and is not insurance and does not participate in the Idaho Life and Guaranty Association.

SAV-RX Prescription Services

Regence

Regence BlueShield of Idaho is an Independent Licensee of the BlueCross and BlueShield Association

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BFPT, 10017672, EFF DATE 010124

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, cost sharing and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, cost sharing, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, cost sharing, and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're <u>never</u> required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

<u>When balance billing isn't allowed, you also have these protections:</u>

- You're only responsible for paying your share of the cost (like the copayments, cost sharing, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.

- Generally, your health plan must:
    - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, contact **www.cms.gov/nosurprises/consumers** or call the No Surprises Help Desk at 1-800-985-3059.

Visit **www.cms.gov/nosurprises/consumers** for more information about your rights under federal law.

NONDISCRIMINATION NOTICE

Regence complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Regence does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Regence:
Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, and accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services listed above, please contact:

Medicare Customer Service
1-800-541-8981 (TTY: 711)

Customer Service for all other plans
1-888-344-6347 (TTY: 711)

If you believe that Regence has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our civil rights coordinator below:

Medicare Customer Service
Civil Rights Coordinator
MS: B32AG, PO Box 1827
Medford, OR 97501
1-866-749-0355, (TTY: 711)
Fax: 1-888-309-8784
medicareappeals@regence.com

Customer Service for all other plans
Civil Rights Coordinator
MS CS B32B, P.O. Box 1271
Portland, OR 97207-1271
1-888-344-6347, (TTY: 711)
CS@regence.com

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

U.S. Department of Health and Human Services
200 Independence Avenue SW,
Room 509F HHH Building
Washington, DC 20201

1-800-368-1019, 800-537-7697 (TDD).

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

Language assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-344-6347 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-344-6347 (TTY: 711)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-344-6347 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-344-6347 (TTY: 711) 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-344-6347 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-344-6347 (телетайп: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-344-6347 (ATS : 711)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-888-344-6347（TTY:711）まで、お電話にてご連絡ください。

Díí baa akó nínízin: Díí saad bee yáníłti'go **Diné Bizaad**, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 1-888-344-6347 (TTY: 711.)

FAKATOKANGA'I: Kapau 'oku ke Lea-Fakatonga, ko e kau tokoni fakatonu lea 'oku nau fai atu ha tokoni ta'etotongi, pea te ke lava 'o ma'u ia. ha'o telefonimai mai ki he fika 1-888-344-6347 (TTY: 711)

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-888-344-6347 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711)

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-888-344-6347 (TTY: 711)។

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-888-344-6347 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachdienstleistungen zur Verfügung. Rufnummer: 1-888-344-6347 (TTY: 711)

ማስታወሻ:- የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፤ በሚከተለው ቁጥር ይደውሉ 1-888-344-6347 (መስማት ለተሳናቸው:- 711)።

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-888-344-6347 (телетайп: 711)

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-888-344-6347 (टिटिवाइ: 711

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-888-344-6347 (TTY: 711)

MAANDO: To a waawi [Adamawa], e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1-888-344-6347 (TTY: 711)

โปรดทราบ: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-888-344-6347 (TTY: 711)

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-888-344-6347 (TTY: 711)

Afaan dubbattan Oroomiffaa tiif, tajaajila gargaarsa afaanii tola ni jira. 1-888-344-6347 (TTY: 711) tiin bilbilaa.

توجه: اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-888-344-6347 (TTY: 711) تماس بگیرید.

ملحوظة: إذا كنت تتحدث فاذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-344-6347 (رقم هاتف الصم والبكم TTY: 711)

Dear ERHC Plan Members:

You have chosen to enroll in the Boise Fire & Police Trust's ERHC Plan for 2024.

As you know, this Plan involves a "capitated care" arrangement between the Trust and Dr. Rob Hilvers' Emergency Responders Health Center ("ERHC"), whereby the Trust pays ERHC a monthly fee to provide you and your eligible family members many basic primary care needs at no out-of-pocket cost to you. A list of these capitated care services is contained in Section 1 of Appendix 1 attached to this Plan Document and Booklet ("Plan Booklet").

Regence is the Claims Administrator chosen by the Trust to administer all claims for services other than services listed in Section 1 of Appendix 1 provided by ERHC.

Although you are not required to go to ERHC for all of the services listed in Appendix 1, Section 1, ERHC will provide those services at no out-of-pocket cost to you. Claims for any such services you receive elsewhere will be administered by Regence and subject to all the terms of this Plan Booklet, as will claims for all services not listed in Appendix 1, Section 1, whether provided by ERHC or another provider.

Section 2 of Appendix 1 lists examples of some services, such as specialist visits and hospital care, which are outside the scope of the capitated care services that are provided at no out-of-pocket cost to you.

Appendix 1, Section 4 contains the separate claims and appeal procedures which apply to the ERHC capitated care arrangement.

We value your input. Please let us know about your experience with ERHC, or any other aspect of this Plan.

Thank you.

The Boise Fire & Police Trust Board of Trustees

Introduction

Welcome to participation in the self-funded group health plan (hereafter referred to as "Plan") provided to You through the Boise Fire & Police Trust (hereafter referred to as "Trust"). The Trust is operated through the actions of a Board of Trustees. The Trust was established by the Plan Sponsors, Boise Firefighters International Association of Fire Fighters Local 149 and Boise Police International Brotherhood of Police Officers Local 486, in accordance with a Memorandum of Agreement between those two local unions and the City of Boise.

Your benefits are administered by Regence BlueShield of Idaho, Inc. (hereafter referred to as "Regence BlueShield of Idaho" or the "Claims Administrator") pursuant to an administrative services agreement with the Trust (hereinafter referred to as the "Agreement"). Your prescription medication benefits are administered by the Prescription Benefit Manager Sav-Rx Prescription Services (usually referred to as "Sav-Rx" or "PBM").

Your covered medical and prescription medication services and supplies are paid for by funds from the Trust and from Your own Contributions, as applicable. The Claims Administrator and PBM provide administrative claims payment services only and do not assume any financial risk or obligation with respect to claims. The Trust is also assisted in day-to-day administration of the Plan by a third-party administrator, Vimly Benefit Solutions, Inc.

This Plan Document and the Booklet provide the written description of the terms and benefits of coverage available under the Plan.

This Booklet describes benefits effective **January 1, 2024**, or the date Your coverage became effective. All covered benefits are subject to the terms, conditions, exclusions, and limitations in this Booklet. This Plan Document and the Booklet replace any plan description, Booklet or certificate previously issued by Regence BlueShield of Idaho and makes it void. The "identification card" issued to You includes Your name and Your identification number for this coverage. Present Your identification card to Your Provider before receiving care.

In this Booklet, the term "Claims Administrator" refers to Regence BlueShield of Idaho, Inc. and the term "Plan" refers to the Trust. References to "You" and "Your" refer to the Participant and/or Beneficiaries. Other terms are defined in the Definitions Section or where they are first used and are designated by the first letter being capitalized.

The Claims Administrator provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims. This means that the Trust, not Regence BlueShield of Idaho, pays for Your covered medical services and supplies. Your claims will be paid only after the Trust provides the Claims Administrator with the funds to pay Your benefits and pay all other charges due under the Plan.

This Plan is not governed by the Employee Retirement Income Security Act (ERISA).

Notice of Privacy Practices: Regence BlueShield of Idaho has a Notice of Privacy Practices that is available by calling Customer Service or visiting the website listed below.

CONTACT INFORMATION
For Medical Claims:

Regence BlueShield of Idaho
Customer Service: 1 (866) 240-9580
(TTY: 711)

Phone lines are open Monday – Friday 5 a.m. – 8 p.m. and Saturday 8 a.m. – 4:30 p.m., Pacific Time.

Contact Customer Service:

- if You have questions;

- if You would like to learn more about Your coverage;
- if You would like to request written or electronic information regarding any other plan that the Claims Administrator offers;
- to talk with one of the Claims Administrator's Customer Service representatives;
- via the Claims Administrator's website, **regence.com**, to submit a claim online or chat live with a Customer Service representative;
- to request a copy of Your identification card (or print a copy via the Claims Administrator's website); or
- for assistance in a language other than English.

Case Management: Case managers assess Your needs, develop plans, coordinate resources and negotiate with Providers. For additional information refer to the Medical Benefits Section or call Case Management at 1 (866) 543-5765.

BlueCard® Program: This unique program enables You to access Hospitals and Physicians when traveling outside the four-state area Regence BlueShield of Idaho serves (Idaho, Oregon, Utah and Washington), as well as receive care in 200 countries around the world. Call Customer Service to learn how to have access to care through the BlueCard Program.

For Prescription Medication Claims:

Sav-Rx Prescription Services
Customer Service: 1 (800) 228-3108 (24/7/365)
Fax: 1 (888) 810-1394
Website: **www.savrx.com**

As stated above, this document describes the self-insured medical benefits offered through the Trust that are administered by Regence BlueShield of Idaho, as well as the prescription medication benefits administered by Sav-Rx. This document does not describe benefits that may be offered through the Trust that are administered by others, but that are an integrated part of this Plan. For example, the Trust separately provides and administers certain coverages not addressed here such as those relating to hearing, dental, vision benefits, supplemental benefits for planned surgeries, and wellness examinations. These benefits and the associated terms, conditions, and limitations are generally described in other documents that have been and/or will be provided to You; notwithstanding, these benefits and services are provided in connection with and under this Plan. In particular, the general eligibility conditions for these other benefits are the same as specified herein under the "Eligibility and Enrollment" section. If You have any questions about these other benefits, please contact the Trust c/o Vimly Benefit Solutions, Inc., 12121 Harbour Reach Dr, Ste. 105, Mukilteo, WA 98275; 1 (800) 986-3109.

Using Your Booklet

ACCESSING PROVIDERS

You are not restricted in Your choice of Provider for care or treatment of an Illness or Injury. You control Your out-of-pocket expenses by choosing between "Category 1," "Category 2" and "Category 3" benefit levels.

- **Category 1.** Choosing preferred Providers saves You the most in Your out-of-pocket expenses. Preferred Providers will not bill You for balances beyond any Deductible, Copayment and/or Cost-Sharing for Covered Services.
- **Category 2.** Choosing participating Providers means Your out-of-pocket expenses will be higher than choosing a preferred Provider. Participating Providers will not bill You for balances beyond any Deductible, Copayment and/or Cost-Sharing for Covered Services.
- **Category 3.** Choosing nonparticipating Providers means Your out-of-pocket expenses will be higher than choosing a preferred or participating Provider. Also, a nonparticipating Provider may bill You for balances beyond any Deductible, Copayment and/or Cost-Sharing. This is referred to as balance billing. Refer to the notice "Your Rights and Protections Against Surprise Medical Bills" attached to this Booklet for information regarding reimbursement and balance billing applicable to nonparticipating Providers for certain services.

For each benefit, the Provider You may choose and Your payment amount for each provider option is indicated. See the Definitions Section for a complete description of Categories 1, 2 and 3. You can go to **regence.com** for further Provider network information.

ADDITIONAL ADVANTAGES OF PARTICIPATION

The Claims Administrator provides access to discounts on select items and services, personalized health care planning information, health-related events and innovative health-decision tools, as well as a team dedicated to Your personal health care needs. You also have access to the Claims Administrator's website and mobile application to help You navigate Your way through health care decisions. For access, You just set up Your free account once and it is always up to You whether to participate. **THESE SERVICES ARE VOLUNTARY, NOT INSURANCE AND ARE OFFERED IN ADDITION TO THE BENEFITS IN YOUR BOOKLET.** Additional information about some programs and services can be found in the Value-Added Services Appendix at the end of the Booklet.

- **Go to regence.com or the Claims Administrator's mobile application.** You can use the Claims Administrator's secure applications to:

  - view recent claims, benefits and coverage;
  - find a contracting Provider;
  - use tools to estimate upcoming health care costs and otherwise help You manage health care expenses;
  - get suggestions to improve or maintain wellness and participate in self-guided motivational online wellness programs; and
  - access information about Regence Advantages. Regence Advantages is a discount program that gives You access to savings on a variety of health-related products and services. The Claims Administrator has contracted with several program partners, listed on the secure applications, to offer discounts on their products and services, such as hearing care, health and wellness products and vision care.*

*NOTE: If You choose to access these discounts, You may receive savings on an item or service that is covered by this Plan, that also may create savings or administrative fees for the Claims Administrator. **ANY SUCH DISCOUNTS OR COUPONS ARE COMPLEMENTS TO THE PLAN, BUT ARE NOT INSURANCE.**

PRESCRIPTION MEDICATION COVERAGE GUIDANCE AND SERVICE ALONG THE WAY

- To learn more and receive answers about Your prescription medication coverage call 1 (800) 228-3108 to talk with one of the Sav-Rx Customer Service Representatives.

Table of Contents

Understanding Your Benefits

This section provides information to help You understand the terms Maximum Benefits, Deductibles, Copayments, Cost-Sharing and Out-of-Pocket Maximum. These terms are types of cost-sharing specific to Your benefits. You will need to refer to the Medical Benefits and Your Prescription Medication Benefits Administered by Sav-Rx Sections to see what Your benefits are.

MAXIMUM BENEFITS

Some Covered Services may have a specific Maximum Benefit. Those Covered Services will be provided until the specified Maximum Benefit (which may be a number of days, visits, services, supplies, dollar amount or specified time period) has been reached. Refer to the Medical Benefits Section to determine if a Covered Service has a specific Maximum Benefit.

You will be responsible for the total billed charges for Covered Services that are in excess of any Maximum Benefits. You will also be responsible for charges for any other services or supplies not covered by this Plan, regardless of the Provider rendering such services or supplies.

DEDUCTIBLES

The Deductible is the amount You must pay each Calendar Year before the Plan will provide payments for Covered Services. Only Allowed Amounts for Covered Services are applied to satisfy the Deductible.

The Family Deductible is satisfied when any combination of Family members' payments toward each of their individual Deductibles total the Family Deductible amount. No one Family member may contribute more than their individual Deductible amount toward the Family Deductible in a Calendar Year. A Family member does not have to satisfy their individual Deductible if the Family Deductible has already been satisfied.

The Plan does not pay for services applied toward the Deductible. Refer to the benefit sections to see what Covered Services are subject to the Deductible. Any amounts You pay for non-Covered Services, Copayments or amounts in excess of the Allowed Amount do not apply toward the Deductible.

If Covered Services are incurred during the last three months of a Calendar Year and are applied toward the Deductible for that year, then any amount for Covered Services applied toward the Deductible during the last three months will be carried forward and applied toward the Deductible for the following year. If the amount applied toward the Deductible for a Claimant in the last three months of a Calendar Year is greater than the Claimant's individual Deductible in the following year (because the following year's Deductible is lower), then the Claimant's individual Deductible for that following year is met. Further, the full amount applied toward the Claimant's individual Deductible in the last three months of the previous year is applied to the Family Deductible for the following year.

COPAYMENTS

Copayments are a specific dollar amount that You pay directly to the Provider at the time You receive a specified service. A Provider may or may not request any applicable Copayment at the time of service. Refer to the benefit sections to see what Covered Services are subject to a Copayment.

COST-SHARING (PERCENTAGE YOU PAY)

Your Cost-Sharing is the percentage You pay when the Plan's payment is less than 100 percent. The Cost-Sharing varies, depending on the service or supply You received and who rendered it. Your Cost-Sharing applies once You have satisfied the Deductible and/or any applicable Copayment for Covered Services up to any Maximum Benefit. Your Cost-Sharing will be based upon the lesser of either the billed charges or the Allowed Amount. The Plan does not reimburse Providers for charges above the Allowed Amount.

OUT-OF-POCKET MAXIMUM

The Out-of-Pocket Maximum is the most You could pay in a Calendar Year for Covered Services. Your payments of any Deductible, Copayments and/or Cost-Sharing apply to the Out-of-Pocket Maximum, unless specified otherwise.

The Family Out-of-Pocket Maximum is satisfied when any combination of Family members' payments of their Cost-Shares for Covered Services total the Family Out-of-Pocket Maximum. No one Family member may contribute more than their individual Out-of-Pocket Maximum amount toward the Family Out-of-Pocket Maximum in a Calendar Year. A Family member does not have to satisfy their individual Out-of-Pocket Maximum if the Family Out-of-Pocket Maximum has already been satisfied.

Any amounts You pay for non-Covered Services, Category 2 or Category 3 services for Gene Therapy and Adoptive Cellular Therapy or amounts in excess of the Allowed Amount do not apply toward the Out-of-Pocket Maximum. You will continue to be responsible for amounts that do not apply toward the Out-of-Pocket Maximum, even after You reach the Out-of-Pocket Maximum.

Once You reach the Out-of-Pocket Maximum, benefits subject to the Out-of-Pocket Maximum will be paid at 100 percent of the Allowed Amount for the remainder of the Calendar Year. The Cost-Sharing does not change to a higher payment level or apply to the Out-of-Pocket Maximum for some benefits. Refer to the benefit sections to determine if a Covered Service does not apply to the Out-of-Pocket Maximum.

HOW CALENDAR YEAR BENEFITS RENEW

The Deductible, Out-of-Pocket Maximum and Maximum Benefits are calculated on a Calendar Year basis. Each January 1, those Calendar Year maximums begin again. Some benefits have a separate Maximum Benefit based upon a Claimant's Lifetime and do not renew every Calendar Year.

The Agreement is renewed each Plan Year. A Plan Year is the 12-month period following either the Agreement's original Effective Date or subsequent renewal date. If the Agreement renews on a day other than January 1 of any year, any Deductible or Out-of-Pocket Maximum amounts You satisfied before the Agreement's renewal date will carry over into the next Plan Year. If the Deductible and/or Out-of-Pocket Maximum amounts increase during the Calendar Year, You will need to meet the new requirement minus any amount already satisfied from the previous Agreement during the same Calendar Year.

Medical Benefits

This section explains Your benefits and cost-sharing responsibilities for Covered Services. Referrals are not required before You can use any of the benefits of this coverage, including women's health care services. All benefits are listed alphabetically, with the exception of Preventive Care and Immunizations, Office or Urgent Care Visits and Other Professional Services.

Medical services and supplies must be Medically Necessary for the treatment of an Illness or Injury (except for any covered preventive care) and received from a Provider practicing within the scope of their license. All covered benefits are subject to the limitations, exclusions and provisions of this Plan. In some cases, the Plan may limit benefits or coverage to a less costly and Medically Necessary alternative item. A Health Intervention may be medically indicated or otherwise be Medically Necessary, yet not be a Covered Service. See the Definitions Section for descriptions of Medically Necessary and the types of Providers who deliver Covered Services.

If benefits change while You are in the Hospital (or any other facility as an inpatient), coverage will be provided based upon the benefit in effect when the stay began.

Reimbursement may be available when You purchase new medical supplies, equipment and devices from a Provider or from an approved Commercial Seller. New medical supplies, equipment and devices purchased through an approved Commercial Seller are covered at the Category 1 benefit level, with reimbursement based on the lesser of either the amount paid to a preferred Provider for that item or the retail market value for that item. To learn more about how to access reimbursable new retail medical supplies, equipment and devices, visit the Claims Administrator's website or contact Customer Service.

NOTE: If You choose to access new medical supplies, equipment and devices through the Claims Administrator's website, the Claims Administrator may receive administrative fees or similar compensation from the Commercial Seller and/or You may receive discounts or coupons for Your purchases. **ANY SUCH DISCOUNTS OR COUPONS ARE A COMPLEMENT TO THE PLAN.**

CASE MANAGEMENT

Case management is a program designed to provide early detection and intervention in cases of serious Illness or Injury that have the potential for continuing major or complex care. Case managers are experienced, licensed health care professionals. They will provide information, support and guidance and will work with Your Physicians or other health care professionals in supporting Your treatment plan and proposing alternative benefits.

PREAUTHORIZATION

Some Covered Services may require preauthorization. Those services require contracted Providers to obtain preauthorization from the Claims Administrator before providing such services to You. You will not be penalized if the contracted Provider does not obtain preauthorization from the Claims Administrator in advance and the service is determined to be not covered.

Non-contracted Providers are not required to obtain preauthorization from the Claims Administrator prior to providing services. You may be responsible for the cost of services provided by a non-contracted Provider if those services are not Medically Necessary or a Covered Service. You may request that a non-contracted Provider preauthorize services on Your behalf to determine Medical Necessity prior to receiving those services.

A complete list of services and supplies that require preauthorization may be obtained by visiting the Claims Administrator's website at: **regence.com/web/regence_provider/pre-authorization** or by calling Customer Service.

Preauthorization requests should be faxed by Your Provider following the instructions on the Claims Administrator's website.

PREVENTIVE VERSUS DIAGNOSTIC SERVICES

Covered Services may be either preventive or diagnostic. "Preventive" care is intended to prevent an Illness, Injury or to detect problems before symptoms are noticed. "Diagnostic" care treats, investigates or diagnoses a condition by evaluating new symptoms, following up on abnormal test results or monitoring existing problems.

Your Provider's classification of the service as either preventive or diagnostic and any other terms in this Booklet will determine the benefit that applies. For example, colonoscopies and mammograms are covered in the Preventive Care and Immunizations benefit if Your Provider bills them as preventive and they fall within the recommendations identified in that benefit. Otherwise, colonoscopies and mammograms are covered the same as any other Illness or Injury. You may want to ask Your Provider why a Covered Service is ordered or requested.

CALENDAR YEAR DEDUCTIBLES

Per Claimant: $300
Per Family: $600

CALENDAR YEAR OUT-OF-POCKET MAXIMUM (FOR ALL MEDICAL AND PRESCRIPTION MEDICATION SERVICES COMBINED)

Per Claimant: $1,200
Per Family: $1,400

Be aware that Your actual costs for Covered Services provided by a nonparticipating Provider may exceed this Plan's Out-of-Pocket Maximum amount. Also, nonparticipating Providers can bill You for the difference between the amount charged and the Plan's Allowed Amount and that amount does not apply toward any Out-of-Pocket Maximum. Refer to the notice "Your Rights and Protections Against Surprise Medical Bills" attached to this Booklet for information regarding reimbursement and balance billing applicable to nonparticipating Providers for certain services.

PREVENTIVE CARE AND IMMUNIZATIONS

Preventive Care

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: No charge.	**Payment:** No charge.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.

Immunizations – Adult

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: No charge.	**Payment:** No charge.	**Payment:** No charge up to the Allowed Amount and You pay the balance of billed charges.

Immunizations – Childhood

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: No charge.	**Payment:** No charge.	**Payment:** No charge up to the Allowed Amount and You pay the balance of billed charges.

Preventive care and immunization services provided by a professional Provider, facility or Retail Clinic that are within age limits and frequency guidelines according to, and as recommended by, the United States Preventive Service Task Force (USPSTF), the Health Resources and Services Administration (HRSA) or by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC), or as required by state or federal guidance for a specific time period as a result of a government declared disease outbreak, epidemic, or other public health emergency, are covered for the following:

- routine physical examinations, well-women's care, well-baby care and routine health screenings;
- Provider counseling for tobacco use cessation;
- immunizations for adults and children;
- breast pump (including its accompanying supplies) per pregnancy as follows:
    - one new non-Hospital grade breast pump at the Category 1 benefit level when obtained from a Provider (including a Durable Medical Equipment supplier); or
    - a comparable new breast pump may be obtained from an approved Commercial Seller in lieu of a Provider. Benefits for a comparable new breast pump obtained from an approved Commercial Seller will be covered up to the Category 1 benefit level, with reimbursement based on the lesser of either the amount paid to a preferred Provider or the retail market value.
- United States Food and Drug Administration (FDA) approved contraceptive and sterilization methods according to, and as recommended by HRSA, that are obtained in a Provider's office, including, but not limited to:
    - vaginal ring;
    - contraceptive shot/injection;
    - intrauterine devices (both copper and those with progestin);
    - implantable contraceptive rod;
    - surgical implants; and
    - surgical sterilization procedures for women.
- Refer to the Your Prescription Medication Benefits Administered by Sav-Rx Section for coverage of approved contraceptives obtained from a pharmacy, including, but not limited to:
    - condoms;
    - diaphragm with spermicide;
    - sponge with spermicide
    - cervical cap with spermicide;
    - oral contraceptives (combined pill, mini pill and extended/continuous use pill);
    - contraceptive patch; and
    - emergency contraceptives (both levonorgestrel- and ulipristal acetate-containing products.

Prostate cancer screening is also covered when recommended by a Physician or Practitioner. Covered Services for prostate cancer screening include digital rectal examinations and prostate-specific antigen (PSA) tests.

NOTE: Covered Services that do not meet these criteria (for example, diagnostic colonoscopies or diagnostic mammograms) will be covered the same as any other Illness or Injury. In the event HRSA, USPSTF or the CDC adopt a new or revised recommendation, the Plan has up to one year before coverage of the related services must be available and effective. For a list of Covered Services, including information about obtaining a new breast pump from an approved Commercial Seller, visit the Claims Administrator's website or contact Customer Service.

Expanded Immunizations

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.

Immunizations that do not meet age limits and frequency guidelines according to, and as recommended by, the USPSTF, HRSA or by the CDC are covered. Contact Customer Service to verify what expanded immunizations are covered.

Travel Immunizations

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: No charge.	**Payment:** No charge.	**Payment:** No charge up to the Allowed Amount and You pay the balance of billed charges.

Immunizations for travel, occupation or residency in a foreign country are covered.

OFFICE OR URGENT CARE VISITS – ILLNESS OR INJURY

	Category: 1	Category: 2	Category: 3
	Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Primary Physician or Practitioners	**Payment:** You pay $20 Copayment per visit.	**Payment:** You pay $20 Copayment per visit.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.
Specialists (Includes Urgent Care)	**Payment:** You pay $10 Copayment per visit.	**Payment:** You pay $10 Copayment per visit.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.

Office (including home and Hospital outpatient department) and urgent care visits are covered for treatment of Illness or Injury. Coverage does not include other professional services performed in the office or urgent care that are specifically covered elsewhere in the Medical Benefits Section, including, but not limited to, separate facility fees or outpatient radiology and laboratory services billed in conjunction with the visit.

OTHER PROFESSIONAL SERVICES

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.

Services and supplies provided by a professional Provider are covered, subject to any specified limits as explained in the following paragraphs:

Medical Services and Supplies
Professional services, second opinions and supplies, including the services of a Provider whose opinion or advice is requested by the attending Provider.

Services and supplies also include:

- treatment of a Congenital Anomaly;
- Virtual Care service facility fees;
- foot care associated with diabetes; and
- Medically Necessary foot care obtained from a professional Provider due to hazards of a systemic condition causing severe circulatory dysfunction or diminished sensation in the legs or feet.

Additionally, coverage includes certain Medically Necessary supplies (for example, compression stockings, active wound care supplies and sterile gloves) that are new and obtained from an approved Commercial Seller. Benefits for eligible new supplies will be covered up to the Category 1 benefit level, with reimbursement based on the lesser of either the amount paid to a preferred Provider or the retail market value. To verify eligible new medical supplies, find an approved Commercial Seller, instructions for claiming benefits or for additional information on Covered Services, visit the Claims Administrator's website or contact Customer Service.

Diagnostic Procedures
Services for diagnostic procedures including cardiovascular testing, pulmonary function studies, stress tests, sleep studies and neurology/neuromuscular procedures.

Professional Inpatient
Professional inpatient visits for treatment of Illness or Injury. If pre-arranged procedures are performed by a preferred Provider and You are admitted to a preferred Hospital, the Plan will cover associated services (for example, anesthesiologist, radiologist, pathologist, surgical assistant, etc.) provided by participating and nonparticipating Providers at the Category 1 benefit level. Contact the Claims Administrator's Customer Service for further information and guidance.

Radiology and Laboratory
Diagnostic services for treatment of Illness or Injury. This includes Medically Necessary genetic testing and diagnostic mammography services not covered in the Preventive Care and Immunizations benefit.

Generally, claims for independent clinical laboratory services will be submitted to the Blue plan in the location in which the referring Provider is located.

Surgical Services
Surgical services and supplies including the services of a surgeon, an assistant surgeon and an anesthesiologist. Covered Services include vasectomies.

Therapeutic Injections
Therapeutic injections and related supplies, including clotting factor products, when given in a professional Provider's office.

Education and Training
The Plan covers education and training for patient self-management by a non-Physician when provided in a face-to-face setting.

ACCIDENTAL INJURY

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: No charge.	**Payment:** No charge.	**Payment:** No charge up to the Allowed Amount and You pay the balance of billed charges.
Limit: $300 per Claimant per Calendar Year		

Services and supplies for treatment required as a result of an Accidental Injury are covered. Once the Maximum Benefit limit is reached, any additional Covered Services will be covered the same as any other Illness or Injury.

ACUPUNCTURE

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: You pay $10 Copayment per visit.	**Payment:** After Deductible, You pay 40% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.
Limit: 40 visits, combined with Spinal Manipulations, per Claimant per Calendar Year. Acupuncture visits that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services.		

AMBULANCE SERVICES

Category: All
Provider: All
Payment: After Deductible, You pay 20% of the Allowed Amount.

Ambulance services to the nearest Hospital equipped to provide treatment are covered when any other form of transportation would endanger Your health and the transportation is not for personal or convenience purposes. Covered Services include licensed ground and air ambulance Providers.

Claims for ambulance services must include the locations You were transported to and from. The claim should also show the date of service, the patient's name, the group's and Your identification numbers.

APPROVED CLINICAL TRIALS

If You are accepted as a trial participant in an Approved Clinical Trial, Your Routine Patient Costs in connection with an Approved Clinical Trial in which You are enrolled and participating are covered as specified in the Medical Benefits Section. If an Approved Clinical Trial is conducted outside Your state of residence, You may participate and benefits will be provided in accordance with the terms for other covered out-of-state care. Additional specified limits are as further defined.

Definitions

The following definitions apply to this Approved Clinical Trials benefit:

Approved Clinical Trial means 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 and that is a study or investigation:

- approved or funded by one or more of:

- the National Institutes of Health (NIH), the CDC, the Agency for Health Care Research and Quality, the Centers for Medicare & Medicaid or a cooperative group or center of any of those entities; or a cooperative group or center of the Department of Defense (DOD) or the Department of Veteran's Affairs (VA);
- a qualified non-governmental research entity identified in guidelines issued by the NIH for center approval grants; or
- the VA, DOD or Department of Energy, provided it is reviewed and approved through a peer review system that the Department of Health and Human Services has determined both is comparable to that of the NIH and assures unbiased review of the highest scientific standards by qualified individuals without an interest in the outcome of the review.

- conducted under an investigational new drug application reviewed by the FDA or that is a drug trial exempt from having an investigational new drug application.

Life-threatening Condition means a disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Routine Patient Costs means items and services that typically are Covered Services for a Claimant not enrolled in a clinical trial, but do not include:

- an Investigational item, device or service that is the subject of the Approved Clinical Trial;
- items and services provided solely to satisfy data collection and analysis needs and not used in the direct clinical management of the Claimant; or
- a service that is clearly inconsistent with widely accepted and established standards of care for the particular diagnosis.

BLOOD BANK

Category: All
Provider: All
Payment: After Deductible, You pay 20% of the Allowed Amount.

Services and supplies of a blood bank are covered, excluding storage costs.

DENTAL HOSPITALIZATION

Category: 1	**Category: 2**	**Category: 3**
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.

When necessary to safeguard Your health, hospitalization for Dental Services is covered. Covered Services include inpatient and outpatient services and supplies (including anesthesia) at an Ambulatory Surgical Center or Hospital.

DETOXIFICATION

Category: 1	**Category: 2**	**Category: 3**
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 20% of the Allowed Amount and the balance of billed charges.

DIABETIC EDUCATION

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.

Services and supplies for diabetic self-management training and education are covered. Diabetic nutritional counseling and nutritional therapy are covered in the Nutritional Counseling benefit.

DIALYSIS

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.

Services and supplies for inpatient and outpatient dialysis are covered (including outpatient hemodialysis, peritoneal dialysis and hemofiltration).

DURABLE MEDICAL EQUIPMENT

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.

Durable Medical Equipment is covered, including, but not limited to, oxygen equipment, wheelchairs and supplies or equipment associated with diabetes.

Additionally, new Durable Medical Equipment is covered when obtained from an approved Commercial Seller. Benefits for eligible new Durable Medical Equipment will be covered up to the Category 1 benefit level, with reimbursement based on the lesser of either the amount paid to a preferred Provider or the retail market value. To verify eligible new Durable Medical Equipment, find an approved Commercial Seller, instructions for claiming benefits or for additional information on Covered Services, visit the Claims Administrator's website or contact Customer Service.

Generally, claims for the purchase of Durable Medical Equipment will be submitted to the Blue plan in the location in which the equipment was received.

EMERGENCY ROOM (INCLUDING PROFESSIONAL CHARGES)

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: You pay $200 Copayment per visit. This Copayment applies to the facility charge and is waived when You are admitted directly from the emergency room to the Hospital or any other facility on an inpatient basis.	**Payment:** You pay $200 Copayment per visit. This Copayment applies to the facility charge and is waived when You are admitted directly from the emergency room to the Hospital or any other facility on an inpatient basis.	**Payment:** You pay $200 Copayment per visit. This Copayment applies to the facility charge and is waived when You are admitted directly from the emergency room to the Hospital or any other facility on an inpatient basis.

Emergency room services and supplies are covered, including outpatient charges for patient observation, medical screening examinations and Medically Necessary detoxification services that are required for the stabilization of a patient experiencing an Emergency Medical Condition. Emergency room services do not need to be preauthorized.

"Stabilization" means to provide Medically Necessary treatment:

- to assure, within reasonable medical probability, no material deterioration of an Emergency Medical Condition is likely to occur during or to result from, the transfer of the Claimant from a facility; and
- in the case of a covered Claimant, who is pregnant, to perform the delivery (including the placenta).

If admitted to a participating or nonparticipating Hospital directly from the emergency room, services will be covered at the Category 1 benefit level. Contact the Claims Administrator's Customer Service for further information and guidance.

GENE THERAPY AND ADOPTIVE CELLULAR THERAPY

Category: 1	Category: 2	Category: 3
Provider: Centers of Excellence	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 90% of the Allowed Amount. Your payment does not apply toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, You pay 90% of the Allowed Amount and the balance of billed charges. Your payment does not apply toward the Out-of-Pocket Maximum.

Gene therapies, adoptive cellular therapies as well as associated services and supplies are covered for Claimants who fulfill the Medical Necessity criteria.

To be covered at the Category 1 benefit level, gene therapy and/or adoptive cellular therapy must be received from one of the Claims Administrator's Centers of Excellence (COE) facilities that is expressly identified as a COE for that therapy. However, if a COE has not been identified for a covered gene therapy and/or adoptive cellular therapy, that therapy must be received from a preferred Provider to be covered at the Category 1 benefit level. Receiving therapy from one of the Claims Administrator's COE facilities will save the most in Your out-of-pocket expenses. For a list of covered therapies or to identify a COE facility, contact the Claims Administrator's Customer Service, as the lists are subject to change.

Travel Expenses

Payment: You pay 100% of all expenses. Your travel expenses may be reimbursed subject to Your Deductible and travel expense limit.
Limit: $12,000 per Claimant per course of treatment, including companion(s), for transportation, lodging and meal expenses. Additional limitations included below.

Transportation, lodging and meal expenses are covered, subject to the following specified limits:

- based on the generally accepted course of treatment in the United States, the therapy would require an overnight stay of one or more consecutive nights away from home and within reasonable proximity to the treatment area;
- if a COE has been identified for the specified covered therapy, covered treatment must be received from the COE;
- if a COE has not been identified for the specified covered therapy, covered treatment must be received from a preferred Provider;
- coverage is for the Claimant and one companion (or two companions if the Claimant is under the age of 19);
- meal and commercial lodging expenses for the Claimant and companion(s) are subject to the benefit limit; and
- covered transportation expenses to and from the treatment area include only:
    - commercial airfare;
    - commercial train fare; or
    - documented auto mileage (calculated per IRS medical expense allowances).

Additionally, local ground transportation within the treatment area to and from the treatment site is covered during the course of the treatment. The Plan will reimburse You for Covered Services associated with these travel expenses. Documentation of all travel expenses should be retained for reimbursement. Contact the Claims Administrator's Customer Service for further information and guidance.

Coverage does not include incidentals outside of transportation, lodging and meals.

HOME HEALTH CARE

Category: 1	**Category: 2**	**Category: 3**
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.

Home health care is covered when provided by a licensed agency or facility for home health care. Home health care includes all services for patients that would be covered if the patient were in a Hospital or Skilled Nursing Facility.

Durable Medical Equipment associated with home health care services is covered in the Durable Medical Equipment benefit.

HOSPICE CARE

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.
Limit: 14 inpatient or outpatient respite care days per Claimant Lifetime		

Hospice care is covered when provided by a licensed hospice care program. A hospice care program is a coordinated program of home and inpatient care, available 24 hours a day. This program uses an interdisciplinary team of personnel to provide comfort and supportive services to a patient and any family members who are caring for a patient, who is experiencing a life-threatening disease with a limited prognosis. These services include acute, respite and home care to meet the physical, psychosocial and special needs of a patient and their family during the final stages of Illness.

Respite care is also covered to provide continuous care of the Claimant and allow temporary relief to family members from the duties of caring for the Claimant. Respite days that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services. Durable Medical Equipment associated with hospice care is covered in the Durable Medical Equipment benefit.

HOSPITAL CARE – INPATIENT, OUTPATIENT AND AMBULATORY SURGICAL CENTER

Hospital Care

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.

Ambulatory Surgical Center

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.

Services and supplies of a Hospital or an Ambulatory Surgical Center (including services of staff Providers) are covered for treatment of Illness or Injury. Room and board is limited to the Hospital's average semiprivate room rate, except where a private room is determined to be necessary.

INFUSION THERAPY

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.

Inpatient, outpatient and home therapy services, supplies (including infusion pumps) and medications for infusion therapy are covered. Covered Services also include parenteral and enteral therapy.

LAP BAND REMOVAL

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.

The Plan covers Lap Band removal for any Participant who received a Lap Band while covered under a Boise City Health Plan prior to the January 1, 2011 implementation of the Trust's Plans.

MATERNITY CARE

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.

Prenatal and postnatal maternity (pregnancy) care, childbirth (vaginal or cesarean), complications of pregnancy and related conditions are covered. There is no limit for the patient's length of inpatient stay. The attending Provider will determine an appropriate discharge time in consultation with the patient. Coverage also includes termination of pregnancy only when done to preserve the life of the Claimant to the extent such services are permitted under applicable law.

Certain services such as screening for gestational diabetes, breastfeeding support, supplies (for example, a breast pump) and counseling are covered in the Preventive Care and Immunizations benefit.

MEDICAL FOODS

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.

Medical foods for inborn errors of metabolism are covered, including, but not limited to, formulas for Phenylketonuria (PKU). "Medical food" means a food which is formulated to be consumed or administered orally or enterally under the supervision of a Physician. Medical foods are intended for specific dietary management of a disease or condition for which distinctive nutritional requirements, based on recognized scientific principles, are established by medical evaluation.

MENTAL HEALTH OR SUBSTANCE USE DISORDER SERVICES

Inpatient Services

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.

Outpatient Office/Psychotherapy Visits

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: You pay $10 Copayment per visit.	**Payment:** You pay $10 Copayment per visit.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.

Other Outpatient Services

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: No charge.	**Payment:** No charge.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.

Mental Health and Substance Use Disorder Services are covered for treatment of Mental Health Conditions or Substance Use Disorders.

Additionally, applied behavioral analysis (ABA) therapy services are covered for treatment of autism spectrum disorders when prescribed by a duly licensed Provider and performed by a Provider or by another individual who has a Board Certified Behavioral Analysis (BCBA) certification issued by the Behavioral Analyst Certification Board.

Definitions

The following definitions apply to this Mental Health or Substance Use Disorder Services benefit:

Mental Health or Substance Use Disorder Services mean Medically Necessary outpatient services, Residential Care, partial Hospital program or inpatient services provided by a licensed facility or licensed individuals with the exception of court ordered treatment (unless the treatment is Medically Necessary).

Mental Health Conditions mean mental disorders in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association except as otherwise excluded. Mental disorders that accompany an excluded diagnosis are covered.

Residential Care means care in a facility setting that offers a defined course of therapeutic intervention and special programming in a controlled environment that also offers a degree of security, supervision and structure, and is licensed by the appropriate state and local authority to provide such services. Patients also must be medically monitored with 24-hour medical availability and 24-hour onsite clinician services. Residential Care does not include half-way houses, supervised living, group homes, wilderness courses or camps, Outward Bound, outdoor youth programs, outdoor behavioral programs, boarding houses, or settings that primarily either focus on building self-esteem or leadership skills or provide a supportive environment to address long-term social needs. However, services by Physicians or

Practitioners in such settings may be covered if they are billed independently and would otherwise be a Covered Service.

Substance Use Disorders mean substance-related disorders included in the most recent edition of the DSM. Substance Use Disorder does not include addiction to or dependency on tobacco, tobacco products or foods.

NEURODEVELOPMENTAL THERAPY

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: You pay $10 Copayment per visit.	**Payment:** After Deductible, You pay 40% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.

Neurodevelopmental therapy services by a Physician or Practitioner are covered. Covered Services must be to restore or improve function for a Claimant with a neurodevelopmental delay. "Neurodevelopmental delay" means a delay in normal development that is not related to any documented Illness or Injury. Covered Services include only physical therapy, occupational therapy, speech therapy and maintenance services, if significant deterioration of the Claimant's condition would result without the service.

You will not be eligible for both the Rehabilitation Services benefit and this benefit for the same services for the same condition.

NEWBORN CARE

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.

Services and supplies in connection with nursery care for the natural newborn or newly adoptive child are covered by the newborn's own coverage. The Newborn Child must be eligible and enrolled as explained in the Eligibility and Enrollment Section. There is no limit for the newborn's length of inpatient stay. "Newborn care" means the medical services provided to a Newborn Child following birth including Hospital nursery charges, the initial physical examination and a PKU test.

NUTRITIONAL COUNSELING

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.

Services for nutritional counseling and nutritional therapy, such as diabetic counseling, discussions on eating habits, lifestyle choices and dietary interventions are covered for all conditions, including obesity.

ORTHOTIC DEVICES

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.

Braces, splints, orthopedic appliances and orthotic supplies or apparatuses are covered when used to support, align or correct deformities or to improve the function of moving parts of the body.

Additionally, certain orthotic devices that are new are covered when obtained from an approved Commercial Seller. Benefits for eligible new orthotic devices will be covered up to the Category 1 benefit level, with reimbursement based on the lesser of either the amount paid to a preferred Provider or the retail market value. To verify eligible new orthotic devices, find an approved Commercial Seller, instructions for claiming benefits or for additional information on Covered Services, visit the Claims Administrator's website or contact Customer Service.

The Plan may elect to provide benefits for a less costly alternative item. Off-the-shelf shoe inserts and orthopedic shoes are not covered.

PROSTHETIC DEVICES

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.

Prosthetic devices for functional reasons are covered to replace a missing body part, including artificial limbs, external or internal breast prostheses following a mastectomy and maxillofacial prostheses. Prosthetic devices or appliances that are surgically inserted into the body are otherwise covered in the appropriate facility benefit. Additionally, the repair or replacement of a prosthetic device due to normal use or growth of a child is covered.

REHABILITATION SERVICES

Inpatient Services

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.

Outpatient Services

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: You pay $10 Copayment per visit.	**Payment:** After Deductible, You pay 40% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.

Inpatient and outpatient rehabilitation services and accommodations are covered as appropriate and necessary to restore or improve lost function caused by Illness or Injury. "Rehabilitation services" mean physical, occupational and speech therapy services only, including associated services such as massage when provided as a therapeutic intervention.

You will not be eligible for both the Neurodevelopmental Therapy benefit and this benefit for the same services for the same condition.

REPAIR OF TEETH

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.

Services and supplies for treatment required as a result of damage to or loss of sound natural teeth are covered when such damage or loss is due to an Injury.

RETAIL CLINIC OFFICE VISITS

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: You pay $20 Copayment per visit.	**Payment:** You pay $20 Copayment per visit.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.

Office visits in a Retail Clinic are covered for treatment of Illness or Injury. All other professional services performed in the Retail Clinic, not billed as an office visit, or that are not related to the actual visit are not considered an office visit.

SKILLED NURSING FACILITY

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.
Limit: 70 inpatient days per Claimant per Calendar Year		

Inpatient services and supplies of a Skilled Nursing Facility are covered for treatment of Illness, Injury or physical disability. Room and board is limited to the Skilled Nursing Facility's average semiprivate room rate, except where a private room is determined to be necessary.

Skilled Nursing Facility days that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services.

SPINAL MANIPULATIONS

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: You pay $10 Copayment per visit.	**Payment:** After Deductible, You pay 40% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.
Limit: 40 visits, combined with Acupuncture, per Claimant per Calendar Year		

Spinal manipulations are covered. Spinal manipulations that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services. Manipulations of extremities are covered in the Neurodevelopmental Therapy or Rehabilitation Services benefits.

TEMPOROMANDIBULAR JOINT (TMJ) DISORDERS

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.
Limit: $2,000 per Claimant Lifetime.		

Inpatient and outpatient services are covered for treatment of TMJ disorders which have one or more of the following characteristics:

- an abnormal range of motion or limitation of motion;
- arthritic problems;
- internal derangement; and/or
- pain in the musculature.

Covered Services include services that are:

- reasonable and appropriate for the treatment of a TMJ disorder;
- effective for the control or elimination of one or more of the following TMJ disorders:
    - pain;
    - infection;
    - disease;
    - difficulty in speaking; or
    - difficulty in chewing or swallowing food.

TRANSPLANTS

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.

Transplants are covered, including transplant-related services and supplies. Covered Services for a transplant recipient include the following:

- heart;
- lung;
- kidney;
- pancreas;
- liver;
- cornea;
- multivisceral;
- small bowel;
- islet cell; and
- hematopoietic stem cell support (donor stem cells can be collected from either the bone marrow or the peripheral blood). Hematopoietic stem cell support may involve the following donors:

    - either autologous (self-donor);
    - allogeneic (related or unrelated donor);
    - syngeneic (identical twin donor); or
    - umbilical cord blood (only covered for certain conditions).

For a list of covered transplants, contact the Claims Administrator's Customer Service, as the list is subject to change. Gene and/or adoptive cellular therapies are covered in the Gene Therapy and Adoptive Cellular Therapy benefit.

Donor Organ Benefits

Donor organ procurement costs are covered for a recipient. Procurement benefits are limited to:

- selection;
- removal of the organ;
- storage;
- transportation of the surgical harvesting team and the organ; and
- other such procurement costs.

Travel Expenses

Payment: You pay 100% of all expenses. Your travel expenses may be reimbursed at 80%, subject to Your Deductible and travel expense limit.
Limit: 14 days per Claimant per Calendar Year (limit is combined for Claimant and companion(s)). Additional limitations included below.

Transportation, lodging and meal expenses are covered, subject to the following specified limits:

- based on the generally accepted course of treatment in the United States as verified through Your case manager, the transplant would require an overnight stay that is greater than 50 miles away from home and within reasonable proximity to the treatment area;
- based on a transplant episode beginning up to five days prior to the transplant and ending three months post-transplant (or sooner if the Claimant is cleared by the treating Provider to return home);
- coverage is for the Claimant and one companion (or two companions if the Claimant is under the age of 19);
- commercial lodging expenses are limited to $300 per night for the Claimant and companion(s) combined;
- meal expenses are limited to $80 per day for each Claimant or companion(s); and
- covered transportation expenses to and from the treatment area include only:

    - commercial airfare;
    - commercial train fare; or
    - documented auto mileage (calculated per IRS medical expense allowances).

Additionally, local ground transportation within the treatment area to and from the treatment site is covered during the course of the transplant treatment. The Plan will reimburse You for Covered Services associated with these travel expenses. Documentation of all travel expenses should be retained for reimbursement. Contact Case Management for further information and guidance.

Coverage does not include travel expenses for the donor.

VIRTUAL CARE

Virtual care services are covered for the use of telehealth or store and forward services received from a remote Provider, rather than an in-person office visit, for the diagnosis, treatment or management of a covered medical condition.

To learn more about how to access virtual care services, visit the Claims Administrator's website or contact Customer Service.

Store and Forward Services

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: You pay $10 Copayment per visit.	**Payment:** You pay $10 Copayment per visit.	**Payment:** After Deductible, You pay 0% of the Allowed Amount and the balance of billed charges.

"Store and forward services" mean secure one-way electronic asynchronous (not live or real-time) electronic transmission (sending) of Your medical information to a Provider which may include some forms of secure HIPAA compliant texting, chatting or data sharing. For example, store and forward services include using a secure patient portal to send a picture of Your swollen ankle to Your Provider for review at a later time. Store and forward services that are not secure and HIPAA compliant are not covered, including, but not limited to:

- telephone;
- facsimile (fax);
- short message service (SMS) texting; or
- e-mail communication.

Your Provider is responsible for meeting applicable requirements and community standards of care.

Telehealth

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: You pay $10 Copayment per visit.	**Payment:** You pay $10 Copayment per visit.	**Payment:** After Deductible, You pay 0% of the Allowed Amount and the balance of billed charges.

"Telehealth" means Your live services (real-time audio-only or audio and video communication) with a remote Provider through a secure HIPAA compliant platform, including when You are in a Provider's office or healthcare facility. For example, telehealth includes a live video call from Your home to discuss a possible eye infection with Your Provider or using the equipment at Your local Provider's office to have a live video call with a cardiologist in a different city. Separate charges for facility fees are covered in the Other Professional Services benefit.

General Exclusions

The following are the general exclusions from coverage, other exclusions may apply as described elsewhere in this Booklet.

SPECIFIC EXCLUSIONS

The following conditions, treatments, services, supplies or accommodations, **including any direct complications or consequences that arise from them**, are not covered. However, these exclusions will not apply with regard to a Covered Service for:

- an Injury, if the Injury results from an act of domestic violence or a medical condition (including physical and mental) and regardless of whether such condition was diagnosed before the Injury, as required by federal law; or
- a preventive service as specified in the Preventive Care and Immunizations Section.

Activity Therapy

The following activity therapy services are not covered:

- creative arts;
- play;
- dance;
- aroma;
- music;
- equine or other animal-assisted;
- recreational or similar therapy; and
- sensory movement groups.

Adventure, Outdoor, or Wilderness Interventions and Camps

Outward Bound, outdoor youth or outdoor behavioral programs, or courses or camps that primarily utilize an outdoor or similar non-traditional setting to provide services that are primarily supportive in nature and rendered by individuals who are not Providers, are not covered, including, but not limited to, interventions or camps focused on:

- building self-esteem or leadership skills;
- losing weight;
- managing diabetes;
- contending with cancer or a terminal diagnosis; or
- living with, controlling or overcoming:
    - blindness;
    - deafness/hardness of hearing;
    - a Mental Health Condition; or
    - a Substance Use Disorder.

Services by Physicians or Practitioners in adventure, outdoor or wilderness settings may be covered if they are billed independently and would otherwise be a Covered Service by the Plan.

Assisted Reproductive Technologies

Assisted reproductive technologies, regardless of underlying condition or circumstance, are not covered, including, but not limited to:

- cryogenic or other preservation, storage and thawing (or comparable preparation) of egg, sperm or embryo;
- in vitro fertilization;
- artificial insemination;
- embryo transfer;
- other artificial means of conception; or

- any associated surgery, medications, testing or supplies.

Certain Therapy, Counseling and Training
The following therapies, counseling and training services are not covered:

- educational;
- vocational;
- social;
- image;
- self-esteem;
- milieu or marathon group therapy;
- premarital or marital counseling;
- employee assistance program services; and
- job skills or sensitivity training.

Conditions Caused by Active Participation in a War or Insurrection
The treatment of any condition caused by or arising out of a Claimant's active participation in a war or insurrection.

Conditions Incurred in or Aggravated During Performances in the Uniformed Services
The treatment of any Claimant's condition that the Secretary of Veterans Affairs determines to have been incurred in, or aggravated during, performance of service in the uniformed services of the United States.

Cosmetic/Reconstructive Services and Supplies
Except for treatment of the following, Cosmetic and/or reconstructive services and supplies are not covered:

- a Congenital Anomaly;
- to restore a physical bodily function lost as a result of Illness or Injury; or
- related to breast reconstruction following a Medically Necessary mastectomy, to the extent required by law. For more information on breast reconstruction, see the Women's Health and Cancer Rights notice.

"Reconstructive" means services, procedures or surgery performed on abnormal structures of the body, caused by Congenital Anomalies, developmental abnormalities, trauma, infection, tumors or disease. It is performed to restore function, but, in the case of significant malformation, is also done to approximate a normal appearance.

Counseling in the Absence of Illness
Except as required by law, counseling in the absence of Illness is not covered.

Custodial Care
Non-skilled care and helping with activities of daily living.

Dental Services
Except as provided in the Repair of Teeth benefit, Dental Services provided to prevent, diagnose or treat diseases or conditions of the teeth and adjacent supporting soft tissues are not covered, including treatment that restores the function of teeth.

Elective Abortion
Except when performed to preserve the life of the enrolled Claimant, to the extent such services are permitted under applicable law, termination of pregnancy (elective abortion) is not covered.

Expenses Before Coverage Begins or After Coverage Ends
Services and supplies incurred before Your Effective Date under the Plan or after Your termination under the Plan.

Family Counseling
Except when provided as part of the treatment for a child or adolescent with a covered diagnosis, family counseling is not covered.

Fees, Taxes, Interest
Except as required by law, the following fees, taxes and interest are not covered:

- charges for shipping and handling, postage, interest or finance charges that a Provider might bill;
- excise, sales or other taxes;
- surcharges;
- tariffs;
- duties;
- assessments; or
- other similar charges whether made by federal, state or local government or by another entity.

Government Programs
Except as required by state law (such as cases of medical emergency or coverage provided by Medicaid) or for facilities that contract with the Claims Administrator, benefits that are covered (or would be covered in the absence of this Plan) by any federal, state or government program are not covered.

Additionally, except as listed below, government facilities or government facilities outside the service area are not covered:

- facilities contracting with the local Blue Cross and/or Blue Shield plan; or
- as required by law for emergency services.

Hearing Aids and Other Devices
Except for cochlear implants, hearing aids (externally worn or surgically implanted), over-the-counter hearing aids, or other hearing devices, including implantation and associated surgical services, are not covered.

Hypnotherapy and Hypnosis Services
Hypnotherapy and hypnosis services and associated expenses are not covered, including, but not limited to:

- treatment of painful physical conditions;
- Mental Health Conditions;
- Substance Use Disorders; or
- for anesthesia purposes.

Illegal Activity
Services and supplies are not covered for treatment of an Illness, Injury or condition caused or sustained by a Claimant's **voluntary participation in** an activity where the Claimant is found guilty of an illegal activity in a criminal proceeding or is found liable for the activity in a civil proceeding. A guilty finding includes a plea of guilty or a no contest plea. If benefits already have been paid before the finding of guilt or liability is reached, the Plan may recover the payment from the person paid or anyone else who has benefited from it.

Illegal Services, Substances and Supplies
Services, substances and supplies that are illegal as defined by state or federal law.

Individualized Education Program (IEP)
Services or supplies, including, but not limited to, supplementary aids and supports as provided in an IEP developed and adopted pursuant to the Individuals with Disabilities Education Act.

Infertility
Except to the extent Covered Services are required to diagnose such condition, treatment of infertility is not covered, including, but not limited to:

- surgery;
- uterine transplants;
- fertility medications; and
- other medications associated with fertility treatment.

Notwithstanding this exclusion, the Trust offers Eligible Participants a fertility benefit solution through Progyny, Inc. outside of the benefits described in this Booklet. Please contact Progyny for more information at 1 (866) 960-3691 or refer to the Fertility and Family Building Benefit Member Guide, which is available on the Vimly Benefits Solutions, Inc. SIMON portal at bfpt.simon365.com or by contacting the Trust Office at 1 (206) 859-2608 or bfpt@vimly.com.

Investigational Services

Except as provided in the Approved Clinical Trials benefit, Investigational services are not covered, including, but not limited to:

- services, supplies and accommodations provided in connection with Investigational treatments or procedures (Health Interventions); and
- any services or supplies provided by an Investigational protocol.

Liposuction for the Treatment of Lipedema

Motor Vehicle Coverage and Other Available Insurance

When motor vehicle coverage, other available insurance or contract is either issued to, or makes benefits available to a Claimant (whether or not the Claimant makes a claim with such coverage), expenses are not covered for services and supplies that are payable by any:

- automobile medical;
- personal injury protection (PIP);
- automobile no-fault coverage (unless the automobile contract contains a coordination of benefits provision, in which case, the Claims Administrator's Coordination of Benefits provision shall apply);
- underinsured or uninsured motorist coverage;
- homeowner's coverage;
- commercial premises coverage;
- excess coverage; or
- similar contract or insurance.

Further, the Claimant is responsible for any cost-sharing required by the other insurance coverage, unless applicable state law requires otherwise. Once benefits in such contract or insurance are exhausted or considered to no longer be Injury-related by the no-fault provisions of the contract, benefits will be provided accordingly.

Non-Direct Patient Care

Except as provided in the Virtual Care benefit, non-direct patient care services are not covered, including, but not limited to:

- appointments scheduled and not kept (missed appointments);
- charges for preparing or duplicating medical reports and chart notes;
- itemized bills or claim forms (even at the Claims Administrator's request); and
- visits or consultations that are not in person (including telephone consultations and e-mail exchanges).

Non-Therapeutic Continuous Glucose Monitors

Obesity or Weight Reduction/Control

Except as provided in the Nutritional Counseling benefit, as required by law or as otherwise provided in this Booklet, services or supplies that are intended to result in or relate to weight reduction (regardless of diagnosis or psychological conditions) are not covered, including, but not limited to:

- medical treatment;
- medications;
- surgical treatment (including treatment of complications, revisions and reversals); or
- programs.

Orthognathic Surgery
Except for treatment of the following, orthognathic surgery is not covered:

- orthognathic surgery due to an Injury;
- temporomandibular joint disorder;
- sleep apnea (specifically, telegnathic surgery);
- developmental anomalies; or
- Congenital Anomaly.

"Orthognathic surgery" means surgery to manipulate facial bones, including the jaw, in patients with facial bone abnormalities resulting from abnormal development performed to restore the proper anatomic and functional relationship of the facial bones.

"Telegnathic surgery" means skeletal (maxillary, mandibular and hyoid) advancement to anatomically enlarge and physiologically stabilize the pharyngeal airway to treat obstructive sleep apnea.

Over-the-Counter Contraceptives
Except as approved by the FDA and prescribed by a Physician or as required by law, the Plan does not cover over-the-counter contraceptive supplies.

Personal Items
Items that are primarily for comfort, convenience, Cosmetics, contentment, hygiene, environmental control, education or general physical fitness are not covered, including, but not limited to:

- telephones;
- televisions;
- air conditioners, air filters or humidifiers;
- whirlpools;
- heat lamps;
- light boxes;
- weightlifting equipment; and
- therapy or service animals, including the cost of training and maintenance.

Physical Exercise Programs and Equipment
Physical exercise programs or equipment are not covered (even if recommended or prescribed by Your Provider), including, but not limited to:

- hot tubs; or
- membership fees to spas, health clubs or other such facilities.

Prescription Medications
Prescription medications dispensed by a pharmacy except as administered by Sav-Rx Prescription Services.

Private-Duty Nursing
Private-duty nursing, including ongoing shift care in the home.

Reversals of Sterilizations
Services and supplies related to reversals of sterilization.

Routine Foot Care

Routine Hearing Examinations

Self-Help, Self-Care, Training or Instructional Programs
Except as provided in the Medical Benefits Section or for services provided without a separate charge in connection with Covered Services that train or educate a Claimant, self-help, non-medical self-care and training or instructional programs are not covered, including, but not limited to:

- childbirth-related classes including infant care; and
- instructional programs that:
    - teach a person how to use Durable Medical Equipment;
    - teach a person how to care for a family member; or
    - provide a supportive environment focusing on the Claimant's long-term social needs when rendered by individuals who are not Providers.

Services and Supplies Provided by a Member of Your Family
Services and supplies provided to You by a member of Your immediate family are not covered.

"Immediate family" means:

- You and Your parents, parents' spouses or domestic partners, spouse or domestic partner, children, stepchildren, siblings and half-siblings;
- Your spouse's or domestic partner's parents, parents' spouses or domestic partners, siblings and half-siblings;
- Your child's or stepchild's spouse or domestic partner; and
- any other of Your relatives by blood or marriage who shares a residence with You.

Services and Supplies That Are Not Medically Necessary
Services and supplies that are not Medically Necessary for the treatment of an Illness or Injury.

Services Required by an Employer or for Administrative or Qualification Purposes
Physical or mental examinations and associated services (laboratory or similar tests) required by an employer or primarily for administrative or qualification purposes are not covered.

Administrative or qualification purposes include, but are not limited to:

- admission to or remaining in:
    - school;
    - a camp;
    - a sports team;
    - the military; or
    - any other institution.
- athletic training evaluation;
- legal proceedings (establishing paternity or custody);
- qualification for:
    - employment or return to work;
    - marriage;
    - insurance;
    - occupational injury benefits;
    - licensure; or
    - certification.
- travel, immigration or emigration.

Sexual Dysfunction
Except as provided in the Mental Health Services benefit, treatment, services and supplies (including medications) are not covered for or in connection with sexual dysfunction regardless of cause.

Third-Party Liability
Services and supplies for treatment of Illness, Injury or health condition for which a third-party is or may be responsible.

Travel and Transportation Expenses
Except as provided in the Ambulance benefit or as otherwise provided in the Medical Benefits Section, travel and transportation expenses are not covered.

Vision Care
Vision care services are not covered, including, but not limited to:

- routine eye examinations;
- vision hardware;
- visual therapy;
- training and eye exercises;
- vision orthoptics;
- surgical procedures to correct refractive errors/astigmatism; and
- reversals or revisions of surgical procedures which alter the refractive character of the eye.

Wigs
Wigs or other hair replacements regardless of the reason for hair loss or absence.

Work-Related Conditions
Except when a Participant is exempt from state or federal workers' compensation law, expenses for services or supplies incurred as a result of any work-related Illness or Injury (even if the service or supply is not covered by workers' compensation benefits) are not covered. This includes any claims resolved as a result of a disputed claim settlement.

If an Illness or Injury could be considered work-related, a Claimant will be required to file a claim for workers' compensation benefits before the Claims Administrator will consider providing any coverage.

Claims Administration

This section explains administration of benefits and claims, including situations that may arise when Your health care expenses are the responsibility of a source other than the Plan. Payment of benefits will be made in accordance with the terms and conditions of this Booklet.

SUBMISSION OF CLAIMS AND REIMBURSEMENT

When claims are submitted and payment is due, the Claims Administrator decides whether to pay You, the Provider or You and the Provider jointly. The Plan may make benefit payments for a child covered by a legal qualified medical child support order (QMCSO) directly to the custodial parent or legal guardian of such child.

Category 1 and Category 2 Claims and Reimbursement

You must present Your identification card to a preferred or participating Provider and furnish any additional information requested. The Provider will submit the necessary forms and information to the Claims Administrator for processing Your claim.

The Plan will pay a preferred or participating Provider directly for Covered Services. These Providers may require You to pay any Deductible, Copayment and/or Cost-Sharing at the time You receive care or treatment. Preferred and participating Providers have agreed not to bill You for balances beyond any Deductible, Copayment and/or Cost-Sharing and to accept the Allowed Amount as payment in full for Covered Services.

Category 3 Claims and Reimbursement

In order for the Claims Administrator to pay for Covered Services, You or the nonparticipating Provider must first send the Claims Administrator a claim. In most cases, the Plan will pay You directly for Covered Services provided by a nonparticipating Provider. Be sure the claim is complete and includes the following information:

- an itemized description of the services given and the charges for them;
- the date treatment was given;
- the diagnosis;
- the patient's name;
- Your identification number; and
- the group number.

If the treatment is for an Injury, include a statement explaining the date, time, place and circumstances of the Injury when You send the Claims Administrator the claim.

Nonparticipating Providers have not agreed to accept the Allowed Amount as payment in full for Covered Services. You are responsible for paying any difference between the amount billed by the nonparticipating Provider and the Allowed Amount in addition to any amount You must pay due to any Deductible, Copayment and/or Cost-Sharing. For nonparticipating Providers, the Allowed Amount may be based upon the billed charges for some services, as determined by the Claims Administrator or as otherwise required by law.

NOTE: Refer to the notice "Your Rights and Protections Against Surprise Medical Bills" attached to this Booklet for information regarding reimbursement and balance billing applicable to nonparticipating Providers for certain services.

Timely Filing of Claims

Written proof of loss (submission of a claim) must be received within one year after the date of service. Claims that are not filed in a timely manner will be denied, unless You can reasonably demonstrate that the claim could not have been filed in a timely manner. Benefits or coverage will not be invalidated nor reduced if it can be shown that it was not reasonably possible to file the claim and that the claim was submitted as soon as reasonably possible. You may Appeal the denial in accordance with the Appeal process to demonstrate that the claim could not have been filed in a timely manner.

Claim Determinations

Within 30 days of the Claims Administrator's receipt of a claim, the Claims Administrator will notify You of their action. However, this 30-day period may be extended by an additional 15 days due to lack of information or extenuating circumstances. The Claims Administrator will notify You of the extension within the initial 30-day period and provide an explanation of why the extension is necessary.

If the Claims Administrator requires additional information to process the claim, the Claims Administrator must allow You at least 45 days to provide it to them. If the Claims Administrator does not receive the requested information within the time allowed, the Claims Administrator will deny the claim.

CONTINUITY OF CARE

You may qualify to receive 90 days of continued coverage (or 90 days from the date You are no longer a continuing care patient, whichever is earlier) at the Category 1 or Category 2 benefit level, if Your Provider was a contracted preferred or participating Provider, but is no longer contracted (this provision does not apply if the contract with the Provider was terminated due to a failure to meet quality standards or for fraud).

To qualify for continued coverage, You must be:

- undergoing a course of treatment for a certain serious and complex condition from the Provider;
- undergoing a course of institutional or inpatient care from the Provider;
- scheduled to undergo non-elective surgery from the Provider (including postoperative care following surgery);
- pregnant and undergoing a course of treatment for pregnancy from the Provider; or
- determined to be terminally ill and receiving treatment for such Illness from the Provider.

The Claims Administrator will notify You of Your right to receive continued care from the Provider or You may contact the Claims Administrator with a need for continued care. Coverage under this Continuity of Care provision will be subject to the benefits of this Plan and provided on the same terms and conditions as any other preferred or participating Provider. Your Provider must accept the Allowed Amount and cannot bill You for any amount beyond any Deductible, Copayment and/or Cost-Sharing. Contact the Claims Administrator's Customer Service for further information and guidance.

OUT-OF-AREA SERVICES

The Claims 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 work based on rules and procedures issued by the Blue Cross Blue Shield Association. Whenever You access health care services outside the geographic area the Claims Administrator serves, the claims for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When You receive care outside the Claims Administrator's service area, You will receive it from one of two kinds of Providers. Most Providers ("participating Providers") contract with the local Blue Cross and/or Blue Shield Licensee in that geographic area ("Host Blue"). Some Providers ("nonparticipating Providers") don't contract with the Host Blue. The Booklet explains below how the Plan pays both kinds of Providers.

BlueCard Program

In the BlueCard Program, when You access Covered Services within the geographic area served by a Host Blue, the Claims Administrator will remain responsible for doing what the Claims Administrator agreed to in the Agreement. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating Providers.

Whenever You receive Covered Services outside the Claims Administrator's service area and the claim is processed through the BlueCard Program, the amount You pay for Covered Services is calculated based on the lower of:

- the billed covered charges for Your Covered Services; or

- the negotiated price that the Host Blue makes available to the Claims Administrator.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to Your health care Provider. Sometimes, it is an estimated price that takes into account special arrangements with Your health care Provider or Provider group that may include types of settlements, incentive payments and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of health care Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing of claims, as noted above. However, such adjustments will not affect the price the Claims Administrator has used for Your claim because they will not be applied after a claim has already been paid.

Value-Based Programs

If You receive Covered Services from a Value-Based Program inside a Host Blue's service area, You will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordination Fees that are a part of such an arrangement, except when a Host Blue passes these fees to the Claims Administrator through average pricing or fee schedule adjustments.

The following definitions apply:

- Value-Based Program: An outcomes-based payment arrangement and/or a coordinated care model facilitated with one or more local Providers that is evaluated against cost and quality metrics/factors and is reflected in Provider payment.
- Provider Incentive: An additional amount of compensation paid to a health care Provider by a Blue Cross and/or Blue Shield Plan, based on the Provider's compliance with agreed-upon procedural and/or outcome measures for a particular group of covered persons.
- Care Coordination Fee: A fixed amount paid by a Blue Cross and/or Blue Shield Licensee to Providers periodically for Care Coordination in a Value-Based Program.

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

Federal law or state law may require a surcharge, tax or other fee that applies to insured accounts. If applicable, the Claims Administrator will include any such surcharge, tax or other fee as part of the claim charge passed on to You.

Nonparticipating Providers Outside the Claims Administrator's Service Area

- **Your Liability Calculation.** When Covered Services are provided outside of the Claims Administrator's service area by nonparticipating Providers, the amount You pay for such services will normally be based on either the Host Blue's nonparticipating Provider local payment or the pricing arrangements required by applicable state law. In these situations, You may be responsible for the difference between the amount that the nonparticipating Provider bills and the payment the Claims Administrator will make for the Covered Services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for nonparticipating emergency services.
- **Exceptions.** In certain situations, the Claims Administrator may use other payment methods, such as billed covered charges, the payment the Claims Administrator would make if the health care services had been obtained within the Claims Administrator's service area, or a special negotiated payment to determine the amount the Claims Administrator will pay for services provided by nonparticipating Providers. In these situations, You may be liable for the difference between the amount that the nonparticipating Provider bills and the payment the Claims Administrator will make for the Covered Services as set forth in this paragraph.

BLUE CROSS BLUE SHIELD GLOBAL® CORE

If You are outside the United States (hereinafter "BlueCard service area"), You may be able to take advantage of Blue Cross Blue Shield Global Core when accessing Covered Services. Blue Cross Blue Shield Global Core is not served by a Host Blue. As such, when You receive care from Providers outside the BlueCard service area, You will typically have to pay the Providers and submit the claims Yourself to obtain reimbursement for these services.

If You need medical assistance services (including locating a doctor or Hospital) outside the BlueCard service area, You should call the service center at 1 (800) 810-BLUE or call collect at 1 (804) 673-1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a Physician appointment or hospitalization, if necessary.

- **Inpatient Services**
  In most cases, if You contact the service center for assistance, Hospitals will not require You to pay for covered inpatient services, except for Your applicable Deductible, Cost-Sharing, etc. In such cases, the Hospital will submit Your claims to the service center to begin claims processing. However, if You paid in full at the time of services, You must submit a claim to receive reimbursement for Covered Services.

- **Outpatient Services**
  Physicians, urgent care centers and other outpatient Providers located outside the BlueCard service area will typically require You to pay in full at the time of services. You must submit a claim to obtain reimbursement for Covered Services.

- **Submitting a Blue Cross Blue Shield Global Core Claim**
  When You pay for Covered Services outside the BlueCard service area, You must submit a claim to obtain reimbursement. For institutional and professional claims, You should complete a Blue Cross Blue Shield Global Core claim form and send the claim form with the Provider's itemized bill(s) to the service center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of Your claim. The claim form is available from the service center or online at **www.bcbsglobalcore.com**. If You need assistance with Your claim submission, You should call the service center at 1 (800) 810-BLUE or call collect at 1 (804) 673-1177, 24 hours a day, seven days a week.

CLAIMS RECOVERY

If the Plan pays a benefit to which You or Your Beneficiaries were not entitled, or if the Plan pays a person who is not eligible for benefits at all, the Plan has the right to recover the payment from the person the Plan paid or anyone else who benefited from it, including a Provider of services. The Plan's right to recovery includes the right to deduct the mistakenly paid amount from future benefits the Plan would provide the Participant or any Beneficiaries, even if the mistaken payment was not made on that person's behalf.

If the Plan makes an overpayment to a Provider, the Claims Administrator may reduce payments to the Provider, in the amount of the overpayment, for otherwise Covered Services for current and/or future Provider claims on Your or Your Beneficiaries' behalf. If a Provider to whom an overpayment was made has patients who are participants in other health plans insured or administered by the Claims Administrator, the Claims Administrator may reduce payments otherwise owed to the Provider from such other health plans by the amount of the overpayment.

The Claims Administrator regularly works to identify and recover claims payments that should not have been made (for example, claims that are the responsibility of another, duplicates, errors, fraudulent claims, etc.). The Plan will be credited all amounts recovered.

This Claims Recovery provision in no way reduces the Plan's right to reimbursement or subrogation. Refer to the Subrogation and Right of Recovery provision for additional information.

SUBROGATION AND RIGHT OF RECOVERY

The provisions of this section apply to all current or former Claimants who incur claims and are or have been covered by the Plan. No adult Claimant hereunder, may assign any rights that they may have to recover expenses from any tortfeasor or other person or entity to any minor child or children of said adult Claimant without the prior express written consent of the Plan. These provisions will apply to all claims arising from Your Illness, Injury or condition, including, but not limited to, wrongful death, survival or survivorship claims brought on Your, Your estate's or Your heirs' behalf, regardless of whether medical expenses were or could be claimed. "You" or "Your" includes anyone on whose behalf the Plan pays benefits.

The Plan's Right of Subrogation or reimbursement, as set forth below, extend to all insurance coverage available to You due to an Illness, Injury or condition for which the Plan has paid medical claims (including, but not limited to, liability coverage, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers compensation coverage, no fault automobile coverage or any first party insurance coverage).

This Plan is always secondary to automobile no-fault coverage, personal injury protection coverage, or medical payments coverage, excess coverage or similar contract or insurance.

No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until this Plan's subrogation and reimbursement interest are fully satisfied.

Subrogation

The "Right of Subrogation" means the Plan is entitled to pursue any claims that You may have in order to recover the benefits paid by the Plan. Immediately upon paying or providing any benefit under the Plan, the Plan shall be subrogated to (stand in the place of) all of Your rights of recovery with respect to any claim or potential claim against any party, due to an Illness, Injury or condition to the full extent of benefits provided or to be provided by the Plan. The Plan may assert a claim or file suit in Your name and take appropriate action to assert its subrogation claim, with or without Your consent. The Plan is not required to pay You part of any recovery it may obtain, even if it files suit in Your name.

Reimbursement

If You receive any payment as a result of an Illness, Injury or condition, You agree to reimburse the Plan first from such payment for all amounts the Plan has paid and will pay as a result of that Illness, Injury or condition, up to and including the full amount of Your recovery. Benefit payments made under the Plan are conditioned upon Your agreement to reimburse the Plan in full from any recovery You receive for Your Illness, Injury or condition.

Constructive Trust

By accepting benefits (whether the payment of such benefits is made to You or made on Your behalf to any Provider) You agree that if You receive any payment as a result of an Illness, Injury or condition, You will serve as a constructive trustee over those funds. Failure to hold such funds in trust will be deemed a breach of Your fiduciary duty to the Plan. No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until this Plan's subrogation and reimbursement interest are fully satisfied.

Lien Rights

Further, the Plan will automatically have a lien to the extent of benefits paid by the Plan for the treatment of the Illness, Injury or condition upon any recovery whether by settlement, judgment or otherwise, related to treatment for any Illness, Injury or condition for which the Plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the Plan including, but not limited to, You, Your representative or agent, and/or any other source that possessed or will possess funds representing the amount of benefits paid by the Plan.

Assignment

In order to secure the Plan's recovery rights, You agree to assign to the Plan any benefits or claims or rights of recovery You have in any automobile policy or other coverage, to the full extent of the Plan's subrogation and reimbursement claims. This assignment allows the Plan to pursue any claim You may have, whether or not You choose to pursue the claim.

First-Priority Claim

By accepting benefits from the Plan, You acknowledge that the Plan's recovery rights are a first priority claim and are to be repaid to the Plan before You receive any recovery for Your damages. The Plan shall be entitled to full reimbursement on a first-dollar basis from any payments, even if such payment to the Plan will result in a recovery which is insufficient to make You whole or to compensate You in part or in whole for the damages sustained. The Plan is not required to participate in or pay Your court costs or attorney fees to any attorney You hire to pursue Your damage claim.

Applicability to All Settlements and Judgments

The terms of this entire Subrogation and Right of Recovery provision shall apply and the Plan is entitled to full recovery regardless of whether any liability for payment is admitted and regardless of whether the settlement or judgment identifies the benefits the Plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than expenses provided by the Plan. The Plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages and/or general damages only. The Plan's claim will not be reduced due to Your own negligence.

Cooperation

You agree to cooperate fully with the Plan's efforts to recover benefits paid. It is Your duty to notify the Plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of Your intention to pursue or investigate a claim to recover damages or obtain compensation due to Your Illness, Injury or condition. You and Your agents agree to provide the Plan or its representatives notice of any recovery You or Your agents obtain prior to receipt of such recovery funds or within five days if no notice was given prior to receipt of recovery funds. Further, You and Your agents agree to provide notice prior to any disbursement of settlement or any other recovery funds obtained. You and Your agents shall provide all information requested by the Plan, the Claims Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the Plan may reasonably request and all documents related to or filed in personal injury litigation. Failure to provide this information, failure to assist the Plan in pursuit of its subrogation rights or failure to reimburse the Plan from any settlement or recovery You receive may result in the denial of any future benefit payments or claim until the Plan is reimbursed in full, termination of Your health benefits or the institution of court proceedings against You.

You shall do nothing to prejudice the Plan's subrogation or recovery interest or prejudice the Plan's ability to enforce the terms of this Plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the Plan or disbursement of any settlement proceeds or other recovery prior to fully satisfying the Plan's subrogation and reimbursement interest.

You acknowledge that the Plan has the right to conduct an investigation regarding the Illness, Injury or condition to identify potential sources of recovery. The Plan reserves the right to notify all parties and their agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

Workers' Compensation

If the entity providing workers' compensation coverage denies Your claim and You have filed an appeal, benefits may be advanced for Covered Services if You agree to hold any recovery obtained in a segregated account for the Plan.

Future Medical Expenses

Benefits for otherwise Covered Services may be excluded when You have received a recovery from another source relating to an Illness or Injury for which the Plan would normally provide benefits. However, the amount of any Covered Services excluded in this provision will not exceed the amount of Your recovery.

Interpretation

In the event that any claim is made that any part of this Subrogation and Right of Recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Claims Administrator shall have the sole authority to resolve all disputes regarding the interpretation of this provision.

Jurisdiction

By accepting benefits from the Plan, You agree that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the Plan may elect. By accepting such benefits, You hereby submit to each such jurisdiction, waiving whatever rights may correspond by reason of Your

present or future domicile. By accepting such benefits, You also agree to pay all attorneys' fees the Plan incurs in successful attempts to recover amounts the Plan is entitled to per this provision.

COORDINATION OF BENEFITS

If You are covered by any other Plan (as defined below), the benefits in this Booklet and those of the other Plan will be coordinated in accordance with the provisions of this section.

Definitions

The following are definitions that apply to this Coordination of Benefits provision:

Allowable Expense means, with regard to services that are covered in full or part by this Plan or any other Plan(s) covering You, the amount on which that Plan would base its benefit payment for a service, including Cost-Sharing or Copayments and without reduction for any applicable Deductible. In no event shall benefits payable under this Plan and another Plan exceed the allowable charges for such benefits. The following are examples of expenses that are not an Allowable Expense:

- An expense or portion of an expense not covered by any of Your involved Plans.
- The difference between the cost of a private Hospital room and the cost of a semiprivate Hospital room, unless Your stay in a private Hospital room is Medically Necessary or one of Your involved Plans provides coverage for private Hospital rooms.
- Any expenses for other types of coverage or benefits when this coverage restricts coordination of benefits to certain types of coverage or benefits. This Coordination of Benefits provision applies to all benefits provided in this Booklet.
- Any amount by which a Primary Plan's benefits were reduced because You did not comply with that Plan's provisions regarding second surgical opinion or failed to use a preferred Provider.

When a Plan provides benefits in the form of services, the reasonable cash value of each service provided will be considered both an Allowable Expense and a benefit paid.

Birthday means only the day and month in a Calendar Year and does not include the year in which the Claimant is born.

Closed Panel Plan means a Plan that provides health benefits to a Claimant primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member. If the Primary Plan is a Closed Panel Plan and the Secondary Plan is not a Closed Panel Plan, the Secondary Plan shall provide benefits as if it were the Primary Plan when a Claimant uses a non-panel provider, except for emergency services or authorized referrals that are provided by the Primary Plan.

Custodial Parent means the parent awarded custody of a child by a court decree. In the absence of a court decree, the parent with whom the child resides more than one half of the Calendar Year without regard to any temporary visitation is the Custodial Parent.

Group-Type Coverage is a coverage that is not available to the general public and can be obtained and maintained only because of membership in or connection with a particular organization or group, including blanket coverage. Group-Type Coverage does not include an individually underwritten and issued guaranteed renewable coverage, even if the coverage is purchased through payroll deduction at a contribution savings to the covered person.

Plan means any of the following with which this coverage coordinates benefits:

- group and non-group insurance contracts and subscriber contracts;
- uninsured group or Group-Type Coverage arrangements;
- group and non-group coverage through Closed Panel Plans;
- Group-Type Coverage;
- medical care components of long-term care coverage, such as skilled nursing care;
- Medicare or other governmental benefits, except as provided below; and

- medical benefits coverage in automobile "no fault" and traditional automobile "fault" type contracts.

Plan does **not** include:

- hospital indemnity coverage or other fixed indemnity coverage;
- school accident-type coverage that covers students for accidents only, including athletic injuries, either on a 24-hour basis or a "to and from school basis";
- specified disease or specified accident coverage;
- accident only coverage;
- long-term care insurance for non-medical services (such as personal care, adult daycare, homemaker services, assistance with activities of daily living, respite care and Custodial Care) or that pay a fixed daily benefit without regard to actual expenses incurred or services;
- limited benefit health coverage;
- Medicare supplement coverage;
- a Medicaid state plan; or
- a governmental plan that, by law, provides benefits that are excess to those of private insurance or other nongovernmental coverage.

Primary Plan means the Plan that must determine its benefits for Your health care before the benefits of another Plan and without taking the existence of that other Plan into consideration. (This is also referred to as that Plan being "primary" to that other Plan.) There may be more than one Primary Plan. A Plan is a Primary Plan with regard to another Plan in any of the following circumstances:

- the Plan either has no order of benefit determination provision, or its rules differ from those permitted in this provision; or
- both Plans use the order of benefit determination provision included herein and by that provision the Plan determines its benefits first.

Secondary Plan means a Plan that is not a Primary Plan. You may have more than one Secondary Plan. If You are covered by more than one Secondary Plan, the order of benefit determination provision decides the order in which Your Secondary Plans' benefits are determined in relation to each other.

Year means Calendar Year (January 1 through December 31).

Order of Benefit Determination

The order of benefit determination is identified by using the first of the following rules that apply:

Non-dependent Coverage: A Plan that covers You other than as a dependent will be primary to a Plan for which You are covered as a dependent (except where this order of benefits would cause a violation of federal law concerning coordination of benefits with Medicare).

Dependent Coverage: Unless there is a court decree stating otherwise, Plans that cover You as a child shall determine the order of benefits as follows:

For a child whose parents are married or living together (whether or not they have ever been married):

- The Plan that covers You as the dependent of Your parent whose Birthday occurs earlier in the Year will be primary over a Plan that covers You as the dependent of Your parent whose Birthday occurs later in the Year.
- If both parents covering You as a dependent have the same Birthday, the Plan of the parent who has been covered by their Plan longer shall be primary to the Plan of the parent who has been covered by their Plan for a shorter period.

For a child whose parents are divorced, separated or that are not living together (whether or not they have ever been married):

- If a court decree specifies that one of Your parents is responsible for Your health care expenses or health care coverage and that parent's Plan has actual knowledge of that term of the decree, the Plan of that parent is primary to the Plan of Your other parent. If the parent with responsibility has no

health care coverage for Your health care expenses, but that parent's spouse does, that parent's spouse's Plan is the Primary Plan. If benefits have been paid or provided by a Plan before it has actual knowledge of the term in the court decree, these rules do not apply until that Plan's next Contract Year.

- If a court decree states that both parents are responsible for Your health care expenses or health care coverage, or a court decree states that the parents have joint custody without specifying that one parent has responsibility for Your health care expenses or health care coverage:

    - The Plan that covers You as the dependent of Your parent whose Birthday occurs earlier in the Year will be primary over a Plan that covers You as the dependent of Your parent whose Birthday occurs later in the Year.
    - If both parents covering You as a dependent have the same Birthday, the Plan of the parent who has been covered by their Plan longer shall be primary to the Plan of the parent who has been covered by their Plan for a shorter period.

- If there is no court decree allocating responsibility for Your health care expenses or health care coverage:

    - The Plan covering the Custodial Parent shall be primary to the Plan covering Your Custodial Parent's spouse.
    - The Plan of Your Custodial Parent's spouse shall be primary to the Plan covering Your noncustodial parent.
    - Then the Plan covering Your noncustodial parent shall be primary to the Plan of Your noncustodial parent's spouse.

For a child covered by more than one Plan of individuals who are not the parents of the child, the order of benefit determination shall be determined as per the provisions set forth above as if those individuals were parents of the child.

Active/retired or laid-off employees: A Plan that covers You as an active employee (or as that employee's dependent) is primary to a Plan by which You are covered as a retired or laid off employee (or as the dependent of a retired or laid off employee). If the other Plan does not have this rule and if, as a result, the Plans do not agree on the order of benefits, this rule will not apply.

Continuation coverage: A Plan which covers You as an employee or retired employee, or as an employee's or retired employee's dependent, will be primary to a Plan that is providing continuation coverage (pursuant to COBRA or a right of continuation by state or other federal law). If the other Plan does not have this rule and if, as a result, the Plans do not agree on the order of benefits, this rule will not apply. This paragraph does not apply if an order of benefit determination can be made by the non-dependent coverage paragraph above.

Longer/shorter length of coverage: When none of the paragraphs above establishes an order of benefit determination, the benefits of the Plan that has covered You for the longer period of time will be determined before the benefits of the Plan that has covered You for the shorter period of time. To determine the length of time You have been covered by a Plan, two Plans will be treated as one if You were eligible by the second within 24 hours after the first ended. The start of a new Plan does not include:

- a change in the amount or scope of a Plan's benefits;
- a change in the entity that pays, provides or administers the Plan's benefits; or
- a change from one type of Plan to another (such as from a single-employer Plan to a multiple employer Plan).

Your length of time covered by a Plan is measured from Your first date of coverage with that Plan. If that date is not readily available for a group Plan, the date You first became a member of the group will be used as the date from which to determine the length of time coverage with the present Plan has been in force.

If an order of benefit determination is not identified by the preceding rules, the Plans shall share equally in the Allowable Expenses.

Each of the Plans by which You are covered, and each of the benefits within the Plan, will be considered separately in administering this Coordination of Benefits provision.

Primary Health Plan Benefits

When, in accordance with the order of benefit determination, this coverage is the Primary Plan, the Plan will pay the benefits in this coverage as if no other Plan exists.

Secondary Health Plan Benefits

If, in accordance with the order of benefit determination, one or more Plans are primary to this coverage, the benefits in this Plan will be calculated as follows:

The Claims Administrator will calculate the benefits that the Plan would have paid for a service if this coverage were the Primary Plan. The Claims Administrator will compare the Allowable Expense in this Plan for that service to the Allowable Expense for it with the other Plan(s) by which You are covered. This Plan will pay the lesser of:

- the unpaid charges for the service, up to the higher (highest) Allowable Expenses among the involved Plans, and
- the benefits that the Plan would have paid for the service if this coverage were the Primary Plan.

Deductibles, Cost-Sharing and Copayments in this coverage will be used in the calculation of the benefits that the Plan would have paid if this were the Primary Plan, but they will not be applied to the unpaid charges You owe after the Primary Plan's payment. The Plan's payment therefore will be reduced so that it, when combined with the Primary Plan's payment, does not exceed the higher (highest) Allowable Expense among the involved Plans and the Plan will credit toward any Deductible in this coverage any amount that would have been credited to Deductible if this coverage had been the only Plan.

If this coverage is the Secondary Health Plan according to the order of benefit determination and any other Plan(s) claim to be "always secondary" or use order of benefit determination rules inconsistent with those in this Plan, this Plan will pay its benefits first, but the amount paid will be calculated as if this coverage is a Secondary Health Plan. If the other Plan(s) do not provide the Claims Administrator with the information necessary for the Claims Administrator to determine the Plan's appropriate secondary benefits payment within a reasonable time after their request, the Claims Administrator shall assume their benefits are identical to this Plan's and the Plan will pay benefits accordingly, subject to adjustment upon receipt of the information requested from the other Plan(s) within two years of this Plan's payment.

Nothing contained in this Coordination of Benefits provision requires this Plan to pay for all or part of any service that is not covered by this coverage. Further, in no event will this Coordination of Benefits provision operate to increase the Plan's payment over what the Plan would have paid in the absence of this Coordination of Benefits provision.

Right to Receive and Release Needed Information

Certain facts are needed to apply coordination of benefits provisions. The Claims Administrator has the right to decide which facts they need. The Claims Administrator may get needed facts from, or give them to, any other organization or person as permitted by law, and need not tell or get the consent of any person to do this. You will promptly furnish to the Claims Administrator any information necessary or appropriate to administer this Coordination of Benefits provision. Receipt of such information by the Claims Administrator will be a condition precedent to this Plan's obligation to provide benefits in this Booklet.

Facility of Payment

Any payment made by any other Plan(s) may include an amount that should have been paid by this coverage. If so, the Plan may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid by this coverage. The Plan 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 reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the Plan provides benefits to or on behalf of You in excess of the amount that would have been payable in this Plan by reason of Your coverage with any other Plan(s), the Claims Administrator will be entitled to recover from You, Your assignee or beneficiary, or from the other Plan(s) upon request.

A Secondary Plan that provides benefits in the form of services may recover the reasonable cash value of the services from the Primary Plan to the extent that benefits for the services are covered by the Primary Plan and have not already been paid or provided by it.

Appeal Process

If You or Your Representative (any Representative authorized by You) has a concern regarding a claim denial or other action by the Claims Administrator under the Plan and wishes to have it reviewed, You may Appeal. There are two levels of Appeal, as well as additional voluntary Appeal levels You may pursue. Certain matters requiring quicker consideration may qualify for a level of expedited Appeal and are described separately later in this section.

FILING APPEALS

Appeals, other than a voluntary Appeal to the Board of Trustees, can be initiated through either written or verbal request. A written request appealing a claim denial or other action relating to Medical Benefits can be made by sending it to the Claims Administrator at: Attn: ASO Appeals and Grievances, Regence BlueShield of Idaho, P.O. Box 1106, Lewiston, ID 83501 or facsimile 1 (877) 663-7526. Verbal requests can be made by calling the Claims Administrator's Customer Service.

A written request appealing a claim denial or other action relating to Prescription Medication Benefits can be made by sending it to the PBM at: Attn: Appeals, Sav-Rx Prescription Services, P.O. Box 8, Fremont, NE 68026 or facsimile 1 (888) 810-1394. Verbal requests can be made by calling 1 (800) 228-3108.

Voluntary Appeals to the Board of Trustees must be initiated by a written request, which may be sent to: Board of Trustees, c/o Vimly Benefit Solutions, Inc., 12121 Harbour Reach Dr., Ste. 105, Mukilteo, WA 98275, faxed to 1 (866) 676-1530 or emailed to bfpt@vimly.com provided that verbal requests for voluntary Appeals to the Board of Trustees involving an Expedited Appeal can also be made by calling Vimly Benefit Solutions, Inc. at 1 (206) 859-2608.

Each level of Appeal with the Claims Administrator or the PBM, including expedited Appeals, must be pursued within 180 days of Your receipt of the Claims Administrator's or PBM's determination. You, or Your Representative on Your behalf, will be given a reasonable opportunity to provide written materials. If You don't Appeal within this time period, You will not be able to continue to pursue the Appeal process and may jeopardize Your ability to pursue the matter in any forum.

Requests for a voluntary Appeal to the Board of Trustees must be submitted within 75 days of Your receipt of the Claims Administrator’s or PBM's second-level adverse determination.

If You or Your treating Provider determines that Your health could be jeopardized by waiting for a decision from the regular Appeal process, You or Your treating Provider may specifically request an expedited Appeal within 180 days of Your receipt of the Claims Administrator's determination. See Expedited Appeals later in this section for more information.

First-Level Appeals

First-level Appeals are reviewed by an employee or employees who were not involved in the initial decision that You are Appealing. In Appeals that involve issues requiring medical judgment, the decision is made by the Claims Administrator's or PBM's staff of health care professionals. For Post-Service Appeals, a written notice of the decision will be sent within 30 days of receipt of the Appeal. For Appeals involving a Pre-Service preauthorization of a procedure, the Claims Administrator or PBM will send a written notice of the decision within 14 days of receipt of the Appeal. For Post-Service Appeals involving a service or supply determined to be Investigational, the Claims Administrator or PBM will send a written notice of the decision within 20 working days of receipt of the Appeal.

Second-Level Appeals

Second-level Appeals are reviewed by a panel, the members of which were not involved in, or subordinate to anyone involved in, the previous decisions. Prescription Medication Benefits are not subject to Second-level Appeals. For Post-Service Appeals, a written notice of the decision will be sent within 30 days of receipt of the Appeal. For Appeals involving a Pre-Service preauthorization of a procedure, the Claims Administrator will send a written notice of the decision within 14 days of receipt of the Appeal. For Post-Service Appeals involving a service or supply determined to be Investigational, the Claims Administrator will send a written notice of the decision within 20 working days of receipt of the Appeal.

Voluntary Appeals to the Board of Trustees

Voluntary Appeals are normally reviewed by the Trust's Board of Trustees at the next regular meeting of the Board of Trustees following receipt of Your written request for Board review. **Appeals to the Board of Trustees are strictly voluntary and, unlike First and Second-level Appeals to the Claims Administrator or First-level Appeals to the PBM, need not be pursued in order for You to seek a Voluntary External Appeal, as discussed below.** The Board of Trustees review of a voluntary appeal will generally be limited to information that the appealing Participant presents in support of their appeal (some exceptions might include relevant Plan documents, any information the Board of Trustees may obtain from a retained third-party independent reviewer, and/or information from the Trust's stop loss carrier).

VOLUNTARY EXTERNAL APPEAL – INDEPENDENT REVIEW ORGANIZATION (IRO)

For information regarding a Voluntary External Appeal, refer to the Your Right To An Independent External Review – Notice provision below.

EXPEDITED APPEALS

An expedited Appeal is available if one of the following applies:

- the application of regular Appeal time frames on a Pre-Service or concurrent care claim either:
  - could jeopardize Your life, health or ability to regain maximum function; or
  - according to a Provider with knowledge of Your medical condition, would subject You to severe pain that cannot be adequately managed without the disputed care or treatment.

First-Level Expedited Appeal

The first-level expedited Appeal request should state the need for a decision on an expedited basis and must include documentation necessary for the Appeal decision. First-level expedited Appeals are reviewed by the Claims Administrator's or PBM's staff of healthcare professionals who were not involved in, or subordinate to anyone involved in, the initial denial determination. Verbal notice of the decision will be provided to You and Your Representative as soon as possible after the decision, but no later than 72 hours of receipt of the Appeal. This will be followed by written notification within three working days of the verbal notice.

Voluntary Expedited Appeal to the Board of Trustees

Expedited Appeals that are submitted to the Board of Trustees will be decided on an expedited basis, generally within 72 hours of receipt of the Appeal. **Expedited Appeals to the Board of Trustees are strictly voluntary and, unlike Expedited Appeals to the Claims Administrator, need not be pursued in order for You to seek a Voluntary Expedited Appeal, as discussed below.**

Voluntary Expedited Appeal – IRO

For information regarding a voluntary expedited External Appeal, refer to the Your Right To An Independent External Review - Notice provision below.

YOUR RIGHT TO AN INDEPENDENT EXTERNAL REVIEW – NOTICE

Please read this notice carefully. It describes a procedure for review of a disputed health claim by a qualified professional who has no affiliation with the Claims Administrator. If You request an independent external review of Your claim, the decision made by the independent reviewer will be binding and final on the Trust.

If the Claims Administrator or PBM issues a final adverse benefit determination of Your request to provide or pay for a health care service or supply that is a Covered Service in this Booklet, You may have the right to have the Claims Administrator's or PBM's decision reviewed by health care professionals who have no association with the Claims Administrator or PBM. You have this right only if the Claims Administrator's or PBM's denial decision involved:

- the Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of Your health care service or supply; or

- the Claims Administrator's or PBM's determination that Your health care service or supply was Investigational.

You must first exhaust the Claims Administrator's or PBM's internal grievance and Appeal process. Exhaustion of that process includes completing all levels of Appeal, or unless You requested or agreed to a delay, the Claims Administrator's or PBM's failure to respond to a standard Appeal within 35 days in writing or to an urgent Appeal within three working days of the date You filed Your Appeal. We may also agree to waive the exhaustion requirement for an external review request. You may file for a second-level expedited Appeal with the Claims Administrator and for an expedited external review with the Idaho Department of Insurance at the same time if Your request qualifies as an urgent care request, as defined under the Expedited External Review Request provision below.

No later than four months from the date the Claims Administrator or PBM issues a final notice of denial, You may submit a written request for an external review to: Idaho Department of Insurance, ATTN: External Review, 700 W State Street, 3rd Floor, Boise, Idaho 83720-0043. For more information and for an external review request form see the department's website at **www.doi.idaho.gov**, or call the department's telephone number at 1 (208) 334-4250 or toll-free in Idaho at 1 (800) 721-3272.

You may represent Yourself in Your request or You may name another person, including Your treating health care Provider, to act as Your authorized representative for Your request. If You want someone else to represent You, You must include a signed "Appointment of an Authorized Representative" form with Your request.

Your written external review request to the Department of Insurance must include a completed form authorizing the release of any of Your medical records the Independent Review Organization (IRO) may require to reach a decision on the external review, including any judicial review of the external review decision pursuant to ERISA, if applicable. The department will not act on an external review request without Your completed authorization form.

If Your request qualifies for external review, the Claims Administrator’s or PBM's final adverse benefit determination will be reviewed by an IRO selected by the department. The Plan pays the costs of the review.

Standard External Review Request

You must file Your written external review request with the Department of Insurance within four months after the date the Claims Administrator or PBM issues a final notice of denial.

- Within seven days after the department receives Your request, the department will send a copy to the Claims Administrator or PBM.
- Within 14 days after the Claims Administrator or PBM receives Your request from the department, the Claims Administrator or PBM will review Your request for eligibility. Within five working days after the Claims Administrator or PBM completes that review, the Claims Administrator or PBM will notify You and the department in writing whether Your request is eligible or what additional information is needed. If the Claims Administrator or PBM denies Your eligibility for review, You may Appeal that determination to the department.
- If Your request is eligible for review, the department will assign an IRO to Your review within seven days of the receipt of the Claims Administrator's or PBM's notice. The department will also notify You in writing.
- Within seven days of the date You receive the department's notice of assignment to an IRO, You may submit any additional information in writing to the IRO that You want the IRO to consider in its review.
- The IRO must provide written notice of its decision to You, to the Claims Administrator or PBM and to the department within 42 days after receipt of an external review request. Upon receipt of a notice reversing the final adverse benefit determination, the Claims Administrator or PBM shall approve as soon as reasonably practicable, but no later than one working day after receipt of the decision, the coverage that was the subject of the final adverse benefit determination.

Expedited External Review Request

You may file a written urgent care request with the Department of Insurance for an expedited external review of a Pre-Service or concurrent service denial. You may file for a second-level expedited Appeal with the Claims Administrator or PBM and for an expedited external review request with the department 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 You received emergency services but have not been discharged from a facility, or any Pre-Service or concurrent care claim for medical care or treatment for which application of the time periods for making a regular external review determination:

- could seriously jeopardize Your life or health or ability to regain maximum function;
- in the opinion of the treating health care professional with knowledge of Your medical condition, would subject You to severe pain that cannot be adequately managed without the disputed care or treatment; or
- the treatment would be significantly less effective if not promptly initiated.

The department will send Your expedited external review request to the Claims Administrator or PBM which will determine, no later than the second full working day, whether Your request is eligible for review. The Claims Administrator or PBM will notify You and the department no later than one working day after the decision if Your request is eligible. If the Claims Administrator or PBM denies Your eligibility for review, You may Appeal that determination to the department.

If Your request is eligible for review, the department will assign an IRO to Your review upon receipt of the Claims Administrator's or PBM's notice. The department will also notify You. The IRO must provide notice of its decision to You, to the Claims Administrator or PBM and to the department within 72 hours after the date of receipt of the external review request. The IRO must provide written confirmation of its decision within 48 hours of notice of its decision. If the decision reverses the Claims Administrator's or PBM's denial, the Claims Administrator or PBM will notify You and the department of the intent to pay the Covered Service as soon as reasonably practicable, but not later than one working day after receiving notice of the decision.

Binding Nature Of The External Review Decision

The external review decision by the IRO will be final and binding on both You and the Trust. **This means that if You elect to request external review of Your claim, You will be bound by the decision of the IRO. You will not have any further opportunity for review of Your claim after the IRO issues its final decision.** If You choose 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 IRO is immune from any legal action against it based upon the opinion rendered by the IRO or acts or omissions performed within the scope of its duties unless performed in bad faith or involving gross negligence.

EXTERNAL REVIEW REQUESTS WHEN A VOLUNTARY APPEAL IS REQUESTED

Since appeals to the Board of Trustees are strictly voluntary, they are not considered part of the Claims Administrator’s or PBM's internal grievance and Appeal process that must be exhausted in order to request a voluntary appeal to an Independent Review Organization. The Plan waives any right to assert that a Claimant has failed to exhaust administrative remedies because they did not elect to submit a benefit dispute to the Board of Trustees.

If You timely request an Appeal to the Board of Trustees, the four-month time period for requesting Independent External Review will not commence until the Board of Trustees issues its determination. Otherwise, the four-month time period for requesting Independent External Review commences upon the date of issuance of the Claims Administrator’s or PBM's second-level adverse decision.

INFORMATION

With regard to claims relating to Medical Benefits, if You have any questions about the Appeal Process contact the Claims Administrator's Customer Service or write to the following address: Regence BlueShield of Idaho, P.O. Box 1106, Lewiston, ID 83501 or facsimile 1 (877) 663-7526.

With regard to claims relating to Prescription Medication Benefits, if You have any questions about the Appeal Process outlined here, You may contact the PBM's Customer Service department at 1 (800) 228-3108 or You can write to the PBM's Customer Service department at the following address: Attn: Appeals, Sav-Rx Prescription Services, P.O. Box 8, Fremont, NE 68026 or facsimile 1 (888) 810-1394.

DEFINITIONS

The following definitions apply to this Appeal Process Section:

Appeal means a written or verbal request from a Claimant or, if authorized by the Claimant, the Claimant's Representative, to change a previous decision made by the Claims Administrator or PBM concerning:

- access to health care benefits, including an adverse determination made pursuant to utilization management;
- claims payment, handling or reimbursement for health care services;
- matters pertaining to the contractual relationship between a Claimant and the Plan; and
- other matters as specifically required by state law or regulation.

External Appeal means an Appeal for which You may have the right to have a final adverse benefit determination reviewed by health care professionals who have no association with the Claims Administrator or PBM. You have this right only if the Claims Administrator's or PBM's denial of Your request to provide or pay for a health care service or supply involved:

- the Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of Your health care service or supply; or
- the Claims Administrator's or PBM's determination that Your health care service or supply was Investigational.

Independent Review Organization (IRO) is an independent Physician review organization that acts as the decision-maker for voluntary external Appeals and voluntary external expedited Appeals and that is not controlled by the Claims Administrator or PBM or the Plan.

Post-Service means any claim for benefits that is not considered Pre-Service.

Pre-Service means any claim for benefits which the Claims Administrator or PBM must approve in advance, in whole or in part, in order for a benefit to be paid.

Representative means someone who represents You for the Appeal. The Representative may be an attorney, Your authorized Representative or a treating Provider. It may also be another party, such as a family member, as long as You or Your legal guardian authorize in writing, disclosure of personal information for the Appeal. No authorization is required from the parent(s) or legal guardian of an enrolled dependent child who is less than 13 years old. For expedited Appeals only, a health care professional with knowledge of Your medical condition is recognized as Your Representative. Even if You have previously designated a person as Your Representative for a previous matter, an authorization designating that person as Your Representative in a new matter will be required (but redesignation is not required for each Appeal level). If no authorization exists and is not received in the course of the Appeal, the determination and any personal information will be disclosed to You, Your Representative or Your treating Provider only.

Eligibility and Enrollment

This section explains how to enroll Yourself and/or Your eligible dependents when first eligible, during a period of special enrollment or during an annual open enrollment period. It describes when coverage under the Plan begins for You and/or Your eligible dependents. Payment of any corresponding monthly costs is required for coverage to begin on the indicated dates.

WHO IS ELIGIBLE TO ENROLL

All Eligible Participants will have the opportunity to apply for coverage under the Plan for themselves and their Eligible Dependents. For further details, please see the definitions of Eligible Participant and Eligible Dependent below.

INITIALLY ELIGIBLE AND WHEN COVERAGE BEGINS

You will be entitled to enroll in coverage for Yourself and Your Eligible Dependents within 30 days of initially becoming eligible for coverage per the eligibility requirements in effect under the Trust rules and as stated in the following paragraphs. Coverage for You and Your enrolling Eligible Dependents will begin on the Effective Date.

Except as described under the special enrollment provisions, if You and/or Your Eligible Dependents do not enroll for coverage under the Plan when first eligible or You do not enroll in a timely manner, You and/or Your Eligible Dependents must wait until the next annual open enrollment period to enroll. Eligible Participants and their Eligible Dependents are eligible for coverage following the Trust's receipt of a completed, signed enrollment form or subsequent change form and when the Claims Administrator has enrolled them in coverage under the Plan.

The Effective Date of coverage for Eligible Active Employee Participants and their Eligible Dependents is the first of the month following the first day of Academy or the first of the month following receipt of a complete and signed Enrollment Application.

The Effective Date of coverage for Eligible Retiree Participants and their Eligible Dependents is the first of the month following the end of coverage under the Boise Fire & Police Health Benefit Plan for Active Employees, COBRA, or other group coverage if enrollment in the Boise Fire & Police Retiree Health Plan has been deferred or in the event of reenrollment in the Boise Fire & Police Retiree Health Benefit Plan following a period of continuous other group coverage.

Eligible Participant includes:

- Eligible Active Employee Participants; and
- Eligible Retiree Participants.

Eligible Active Employee Participant means an employee of the City of Boise:

- who is represented by International Association of Fire Fighters Local 149;
- who is represented by International Brotherhood of Police Officers Local 486;
- whose position is listed on Appendix A of the February 12, 2019 Memorandum of Agreement with the City of Boise as a non-bargaining unit uniformed administrative employee who has opted for Coverage under the Trust, rather than to remain covered under the City's health care plans;*
- whose Boise Fire or Police Department Command Staff position was created after October 12, 2010;
- who is promoted to a position listed in Appendix A after January 1, 2011; or
- who comes into a position listed in Appendix A from outside the Boise Fire or Police Department after January 1, 2011, and opts for health care coverage under the Trust.*

*The option for Trust coverage or City coverage is a one-time, irrevocable option offered at the time the individual first becomes eligible for coverage. The individual may not opt to receive cash in place of coverage.

Eligible Dependent includes:

- the Participant's legal spouse (until five years after the Participant becomes entitled to enroll in Medicare) and except for Medicare eligible spouses of Eligible Retiree Participants; and
- the Participant's biological child, stepchild, child legally adopted or legally Placed with the Participant or the Participant's legal spouse for adoption, eligible foster child, as defined in Internal Revenue Service Code § 152(f)(1); or child, other than as defined in Internal Revenue Code § 152((f)(1), for whom the Participant or the Participant's legal spouse has court-appointed guardianship or custody and who receives at least 50 percent of his/her support from the Participant or the Participant's legal spouse. The child must be:

    - under the age of 26; or
    - an unmarried child of any age who is medically certified as disabled and financially dependent upon the Participant.

Eligible Dependent does not include Medicare eligible children of Eligible Retiree Participants.

Eligible Retiree Participant means a retiree of the City of Boise who meets the following requirements:

- The individual must:

    - Be a Boise Fire or Police Department bargaining unit retiree whose name is listed in Appendix B of the February 12, 2019 Memorandum of Agreement with the City of Boise;
    - Be a Boise Fire or Police Department bargaining unit employee retiring between January 1, 2011 and December 31, 2016 (including disability retirements);
    - Be a Boise Fire or Police Department bargaining unit employee retiring on or after January 1, 2017 (including disability retirements) who was employed as a Boise Fire or Police Department bargaining unit employee or as a member of the Boise Fire or Police Department Command Staff for the five (5) years immediately preceding his/her retirement;
    - Be a former member of the Boise Fire or Police Department Command Staff whose name is listed in Appendix C of the February 12, 2019 Memorandum of Agreement with the City of Boise as having opted for coverage under the Trust, rather than to remain covered under the City's health care plans;*
    - Be a Boise Fire or Police Department non-bargaining unit administrative employee retiring between January 1, 2011 and December 31, 2016, who has previously received benefits under the Trust; **or**
    - Be a Boise Fire or Police Department non-bargaining unit administrative employee retiring on or after January 1, 2017, who has previously received benefits under the Trust and who was employed as a Boise Fire or Police Department bargaining unit employee or as a member of the Boise Fire or Police Department Command Staff for the five (5) years immediately preceding his/her retirement.

- In addition:

    - The individual must not be Medicare eligible;
    - The individual must provide proof of other continuous group health plan coverage for themselves (and their dependents, if enrolling) if they did not enroll as a retiree Participant when they first became eligible; **and**
    - The individual must:

        - be receiving a pension check from PERSI (or eligible to be receiving a pension check from PERSI) at the time of separation from employment with the City of Boise Fire or Police Department; or
        - have a combination of years of service as a Fire Fighter or Police Officer for the City of Boise PLUS their age at separation from employment that equal at least 80 ("Rule of 80"); or

- have applied for a disability pension and have exhausted their COBRA rights under the Boise Fire & Police Trust, provided that coverage will be terminated if the application for disability pension is denied.

*The option for coverage is a one-time, irrevocable option offered at the time the individual first becomes eligible for coverage.

Your Beneficiaries are eligible for coverage when You have listed them on the enrollment form or on subsequent change forms and when the Trust has enrolled them in coverage under the Plan.

NEWLY ELIGIBLE DEPENDENTS

You may enroll a dependent who becomes eligible for coverage after Your Effective Date by completing and submitting an enrollment request and the appropriate payment (if any) is received by the Claims Administrator within 31 days of the date the monthly payment invoice is received by the Trust and a notice of payment (if any) is provided to You by the Trust.

Enrollment will be effective from:

- the moment of birth for a Newborn Child if a completed enrollment form is received within 60 days following the date of birth; or
- Placement of a Newly Adopted Child with the Participant for 60 days, but will continue from then on only if a completed enrollment form is received within 60 days following Placement with the Participant.

SPECIAL ENROLLMENT

There are certain situations when You may enroll Yourself and/or Your eligible dependents, even though You didn't do so when first eligible, and You do not have to wait for an annual open enrollment period. You must submit an enrollment form on behalf of all individuals who become eligible based on the provisions below.

If You declined coverage when first eligible, You (unless already enrolled) and/or Your eligible dependents are eligible to enroll for coverage under the Plan within 30 days from the date of one of the following qualifying events:

- You and/or Your eligible dependents lose coverage under another group or individual health benefit plan due to one of the following:
  - an employer's Contributions to that other plan are terminated;
  - exhaustion of federal COBRA or any state continuation; or
  - loss of eligibility due to legal separation, divorce, death, termination of employment or reduction in hours.
- You involuntarily lose coverage under Medicare, CHAMPUS/Tricare, Indian Health Service or a publicly sponsored or subsidized health plan (other than Children's Health Insurance Program (CHIP)).
  - NOTE: If the qualifying event is involuntary loss of coverage with Medicaid or CHIP, You have 60 days from the date of the qualifying event to enroll.
- You lose coverage under Medicaid or CHIP.

For the above qualifying events coverage will be effective on the day after the prior coverage ended. Loss of eligibility does not include a loss because You failed to timely pay Your portion of the cost of coverage or when termination of coverage was due to fraud. It also doesn't include Your decision to terminate coverage. However, it may include Your decision to take another action (for example, terminating employment) that results in a loss of eligibility.

If You declined coverage when first eligible, You (unless already enrolled) and/or Your eligible dependents are eligible to enroll for coverage under the Plan within 60 days from the date of one of the following qualifying events:

- You marry;
- You acquire a new child by birth, adoption or Placement for adoption; or
- You and/or Your eligible dependents become eligible for premium assistance with Medicaid or CHIP.

For the above qualifying events coverage will be effective on the first of the calendar month following the date of the qualifying event. However, if the qualifying event is a child's birth, adoption or Placement for adoption, coverage is effective from the date of the birth, adoption or Placement. Additionally, coverage is effective for a new spouse on the date of marriage if the date of marriage is the first day of a month.

ANNUAL OPEN ENROLLMENT PERIOD

The annual open enrollment period is the only time, other than initial eligibility or a special enrollment period, during which You and/or Your eligible dependents may enroll. During the identified annual enrollment period, and in accordance with the procedures and associated time periods separately communicated to You, You must submit an enrollment form on behalf of all individuals You want enrolled. Coverage will begin on the Effective Date.

DOCUMENTATION OF ELIGIBILITY

You must promptly provide (or coordinate) any necessary and appropriate information to determine the eligibility of a dependent. The Claims Administrator must receive such information before enrolling a person as a dependent under the Plan.

When Coverage Ends

This section describes the situations when coverage will end for You and/or Your Beneficiaries. You must notify the Claims Administrator within 30 days of the date on which a Beneficiary is no longer eligible for coverage.

No person will have a right to receive any benefits after the date coverage is terminated. Termination of Your or Your Beneficiary's coverage under the Plan for any reason will completely end all the Plan's obligations to provide You or Your Beneficiary benefits for Covered Services received after the date of termination. This applies whether or not You or Your Beneficiary is then receiving treatment or is in need of treatment for any Illness or Injury incurred or treated before or while the Plan was in effect.

AGREEMENT TERMINATION

If the Agreement is terminated or not renewed, claims administration by Regence BlueShield of Idaho ends for You and Your Beneficiaries on the date the Agreement is terminated or not renewed. Regence BlueShield of Idaho may administer certain claims for Covered Services that Claimants received before the Agreement termination or nonrenewal, if agreed between the Trust and the Claims Administrator.

WHAT HAPPENS WHEN YOU ARE NO LONGER ELIGIBLE

If You are no longer eligible as explained in the following paragraphs, coverage ends for You and Your Beneficiaries on the last day of the monthly period in which Your eligibility ends. However, it may be possible for You and/or Your Beneficiaries to continue coverage under the Plan according to the COBRA Continuation of Coverage or the Other Continuation Options provisions. As an example of the loss of coverage period discussed above, if someone is no longer eligible because they became Medicare eligible on May 1, their coverage would end on the preceding April 30. Conversely, as another example, if someone is no longer Medicare eligible because of a change in their employment status that occurs on May 15, their coverage would continue through May 31 of that month.

Termination of Your Employment or You are No Longer Eligible

If You are no longer eligible due to termination of employment or You are otherwise no longer eligible according to the terms of the Plan, coverage will end for You and all Beneficiaries on the last day of the monthly period in which eligibility ends.

Nonpayment

If You fail to make required timely Contributions to the cost of coverage, coverage will end for You and all Beneficiaries.

WHAT HAPPENS WHEN YOUR BENEFICIARIES ARE NO LONGER ELIGIBLE

If Your dependent is no longer eligible as explained in the following paragraphs, coverage ends for Your Beneficiaries on the last day of the monthly period in which their eligibility ends. However, it may be possible for an ineligible dependent to continue coverage under the Plan according to the COBRA Continuation of Coverage or the Other Continuation Options provisions.

Divorce or Annulment

Eligibility ends for Your enrolled spouse and the spouse's children (unless such children remain eligible by virtue of their continuing relationship to You) on the last day of the monthly period following the date a divorce or annulment is final.

Death of the Participant

If You die while covered under this Plan, coverage may continue, subject to continued payment of any and all required Contributions, for Your surviving children under age 26 and for Your surviving spouse under the age of 55. When Your surviving spouse attains age 55, they will be eligible to remain covered by paying the then in effect full regular retiree monthly Contribution rate until becoming Medicare eligible, at which point eligibility would cease. The surviving spouse will not, at any time, have the opportunity to add a new spouse.

If You die in the line of duty while covered under this Plan, coverage may continue, subject to continued payment of Contributions at the subsidized retiree monthly Contribution rate for Your surviving spouse

under age 65 and Your surviving children under age 26. Coverage shall cease and may not be reinstated upon Your surviving spouse becoming Medicare eligible or if they cease making required payments. The surviving spouse will not, at any time, have the opportunity to add a new spouse. A line of duty death for purposes of this provision means a death that is the direct and proximate result of personal Injury(ies) sustained in the line of duty consistent with the standards under the Public Safety Officers' Benefits Program.

Loss of Dependent Status

- Eligibility ends on the last day of the monthly period in which an enrolled child exceeds the dependent age limit.
- Eligibility ends on the date in which an enrolled child is removed from Placement due to disruption of Placement before legal adoption.
- Eligibility ends on the last day of the monthly period in which an enrolled child is no longer an eligible dependent for any other cause not described above.

OTHER CAUSES OF TERMINATION

Claimants terminated for the following reason may be able to continue coverage under the Plan according to the COBRA Continuation of Coverage or the Other Continuation Options provisions.

Fraud or Misrepresentation

The Plan is issued in reliance upon all information furnished to the Claims Administrator by You or on behalf of You and Your Beneficiaries. No statement made for effecting coverage will void such coverage or reduce benefits unless such statement is contained in a written instrument signed by You.

In the event of any intentional misrepresentation of material fact or fraud by the Plan Sponsor or Trust, coverage under the Plan will terminate.

FAMILY AND MEDICAL LEAVE

If You are granted a leave of absence per the Family and Medical Leave Act of 1993 (Public Law 103-3, "FMLA") the following rules will apply. The Act is generally applicable to private employers of 50 or more employees and public employers of any size. You will be entitled to continued coverage with this provision only to the extent You are eligible for leave under the terms of the FMLA:

- You and Your Beneficiaries will remain eligible to be enrolled under the Plan during the FMLA leave for a period of up to 12 weeks during a 12-month period for one of the following:
    - to care for Your Newborn Child;
    - to care for Your spouse, child or parent with a serious health condition;
    - the Placement of a child with You for adoption or foster care; or
    - You suffer a serious physical or Mental Health Condition.

During the FMLA leave, You must continue to make payments for coverage on time. The provisions described here will not be available if the Plan terminates.

If You and/or Your Beneficiaries elect not to remain enrolled during the FMLA leave, You (and/or Your Beneficiaries) will be eligible to be reenrolled under the Plan on the date You return from the FMLA leave. In order to reenroll after You return from a FMLA leave, You must sign a new enrollment form as if You were a newly eligible employee. In this situation, if You reenroll within the required time, all of the terms and conditions of the Plan will resume at the time of reenrollment as if there had been no lapse in coverage. You (and/or Your Beneficiaries) will receive credit for any waiting period served before the FMLA leave and You will not have to re-serve any probationary period under the Plan, although You and/or Your Beneficiaries will receive no waiting period credits for the period of noncoverage.

You and/or Your Beneficiaries will not be entitled to any other extension of benefits described in this section for the same situation that entitles them to coverage according to this provision. Entitlement to FMLA leave does not constitute a qualifying event for COBRA continuation. However, a person who does not return to active employment following FMLA leave may be entitled to COBRA continuation

coverage. The duration of that COBRA continuation will be calculated from the date the person fails to return from the FMLA leave.

The provisions and administration described here are based on the requirements of the Family and Medical Leave Act of 1993, as amended, and will be governed by the FMLA law and any subsequent amendments and regulations. If any conflicts arise between the provisions described here and FMLA, the minimum requirements of FMLA will govern. This leave provision is available only to groups that are required by law to comply. The Trust must keep the Claims Administrator advised regarding the eligibility for coverage of any employee who may be entitled to the benefits extended by FMLA.

LEAVE OF ABSENCE

If You are granted a non-FMLA temporary leave of absence by Your employer, You can continue coverage for up to three months. Payments must be made through the Trust in order to maintain coverage during a leave of absence.

A leave of absence is an employer-granted period off work made at Your request during which You are still considered to be employed and are carried on the employer's employment records. A leave can be granted for any reason acceptable to the employer. If You are on leave for an FMLA-qualifying reason, You remain eligible under the Plan only for a period equivalent to FMLA leave and may not also continue coverage with a non-FMLA leave.

Notwithstanding the foregoing, to the extent You remain an employee on unpaid leave, and as long as the City continues to make Contributions to the Trust on Your behalf, coverage shall continue (regardless of FMLA status).

If You and/or Your Beneficiaries elect not to remain enrolled during the leave of absence, You (and/or Your Beneficiaries) may reenroll under the Plan only during the next annual open enrollment period.

CERTIFICATES OF CREDITABLE COVERAGE

Requests for and inquiries about required certificates relating to period(s) of creditable coverage under the Plan should be directed to the Trust, or to the Claims Administrator at P.O. Box 2998, Tacoma, WA 98401-2998.

COBRA Continuation of Coverage

COBRA is a continuation of this coverage for a limited time after certain events cause a loss of eligibility. COBRA continuation does not apply to all groups.

If the Plan is subject to COBRA, COBRA continuation is available to Your Beneficiaries if they lose eligibility because:

- Your employment is terminated (unless the termination is for gross misconduct);
- Your hours of work are reduced;
- You die;
- You and Your spouse divorce or the marriage is annulled;
- You become entitled to Medicare benefits; or
- Your Beneficiary loses eligibility as a child under this coverage.

COBRA also is available to You if You lose eligibility because Your employment terminates (other than for gross misconduct) or Your hours of work are reduced. (A special COBRA continuation also applies to You and Your Beneficiaries per certain conditions if You are retired and Your employer files for bankruptcy.)

There are some circumstances involving disability or the occurrence of a second one of these events that can result in extension of the limited period of continuation following a termination of employment or reduction in working hours. COBRA also can terminate earlier than the maximum periods.

General Rules

You or Your Beneficiaries are responsible for payment of the full cost for COBRA continuation, plus an administration fee, even if the Trust contributes toward the cost of those not on COBRA continuation. The administration fee is two percent or, during any period of extension for disability, 50 percent.

In order to preserve Your and Your Beneficiary's rights with COBRA, You or Your Beneficiaries must inform the Trust in writing within 60 days of:

- Your divorce or annulment or a loss of eligibility of a child;
- Your initial loss of eligibility due to Your termination of employment or reduction in working hours and You experience another one of the events listed above; or
- a Social Security disability determination that You or Your Beneficiary were disabled per Social Security at the time of a termination of employment or reduction in working hours or within the first 60 days of COBRA continuation following that event. (If a final determination is later made that You or Your Beneficiary is no longer disabled per Social Security, You or Your Beneficiary must provide the Trust notice of that determination within 30 days of the date it is made.)

The Trust also must meet certain notification, election and payment deadline requirements. It is very important that You keep the Trust informed of the current address of all Claimants who are or may become qualified beneficiaries.

If You or Your Beneficiaries do not elect COBRA continuation coverage, coverage under the Plan will end according to the terms of the Agreement and the Plan will not pay claims for services provided on and after the date coverage ends. Further, this may jeopardize Your or Your Beneficiaries' future eligibility for an individual plan.

Notice

The Agreement includes additional details on the COBRA Continuation provisions outlined here and complete details are available from the Trust.

Other Continuation Options

This section describes situations when coverage may also be extended for You and/or Your Beneficiaries beyond the date of termination.

Availability of Other Coverage

When eligibility under the Plan terminates at the end of or in lieu of any available COBRA continuation coverage period, or otherwise upon termination of this coverage, an individual insurance policy or Medicare supplement plan is available through Regence BlueShield of Idaho. The policy or plan will have equal or lesser benefits than this coverage.

Pregnancy

If the Plan provided for maternity benefits and any Claimant is pregnant at the time of termination of the Plan and the Claimant is not eligible for any replacement group coverage within 60 days of the termination of the Plan, the Plan will provide benefits for pregnancy, childbirth or miscarriage as detailed in this Booklet for a period not to exceed 12 months beyond the date of termination.

General Provisions and Legal Notices

This section explains various general provisions and legal notices regarding Your benefits under this coverage.

CHOICE OF FORUM
Any legal action arising out of the Plan must be filed in a court in the state of Idaho.

GOVERNING LAW AND DISCRETIONARY LANGUAGE
The Plan will be governed by and construed in accordance with the laws of the United States of America and by applicable laws of the state of Idaho without regard to its conflict of law rules. The Claims Administrator is not the Plan Administrator, but does provide claims administration under the Plan. The Trust has delegated to the Claims Administrator the discretion and authority to interpret Plan terms for the purpose of processing claims and paying benefits.

YOUR ACKNOWLEGMENT AND AGREEMENT TO PLAN TERMS
As a Participant, You are entitled to health care benefits pursuant to the Plan. You, through the enrollment form signed by the Participant, and as Beneficiaries of the Plan, acknowledge and agree to the terms, provisions, limitations and exclusions described in this Booklet.

LIMITATIONS ON LIABILITY
You have the exclusive right to choose a health care Provider. The Plan and the Claims Administrator are not responsible for the quality of health care You receive, since all those who provide care do so as independent contractors. Since the Plan and the Claims Administrator do not provide any health care services, neither can be held liable for any claim or damages connected with Injuries You suffer while receiving health services or supplies provided by professionals who are neither employees nor agents of the Plan or the Claims Administrator.

In addition, the Claims Administrator will not be liable to any person or entity for the inability or failure to procure or provide the benefits in the Plan by reason of epidemic, disaster or other cause or condition beyond the Claims Administrator's control.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT – STATEMENT OF RIGHTS
Under federal law, group health plans and health insurance issuers offering group health insurance coverage may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan or issuer may pay for a shorter stay if the attending Provider, after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, the Plan or issuer may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, the Plan or issuer may not, under federal law, require that a Physician or other health care provider obtain preauthorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain Providers or facilities, or to reduce Your out-of-pocket costs, You may be required to obtain preauthorization. Contact the Claims Administrator's Customer Service for additional information on preauthorization.

NO WAIVER
The failure or refusal of either party to demand strict performance of the Plan or to enforce any provision will not act as or be construed as a waiver of that party's right to later demand its performance or to enforce that provision. No provision of the Plan will be considered waived unless such waiver is reduced to writing and signed by one of the Trust's authorized officers.

NONASSIGNMENT AND NONASSIGNMENT OF VOTING RIGHTS

Only You are entitled to benefits under the Plan. These benefits are not assignable or transferable to anyone else and You (or a custodial parent or the state Medicaid agency, if applicable) may not delegate, in full or in part, benefits or payments to any person, corporation or entity. Any attempted assignment, transfer or delegation of benefits will be considered null and void and will not be binding on the Plan. You may not assign, transfer or delegate any right of representation or collection other than to legal counsel directly authorized by You on a case-by-case basis.

NOTICES

Any notice to Claimants or to the Trust required in the Plan will be considered properly given if written notice is deposited in the United States mail or with a private carrier. Notices to a Participant or to the Trust will be addressed to the last known address appearing in the Claims Administrator's records. If the Claims Administrator receives a United States Postal Service change of address (COA) form for a Participant, the Claims Administrator will update their records accordingly. Additionally, the Claims Administrator may forward notice for a Participant to the Trust if they become aware that the Claims Administrator doesn't have a valid mailing address for the Participant. Any notice to the Claims Administrator required in the Agreement may be mailed to: Regence BlueShield of Idaho, P.O. Box 2998, Tacoma, WA 98401-2998. However, notice to the Claims Administrator will not be considered to have been given to and received by the Claims Administrator until physically received.

RELATIONSHIP TO BLUE CROSS AND BLUE SHIELD ASSOCIATION

The Trust on behalf of the Plan and its Claimants expressly acknowledges its understanding that the Agreement constitutes an agreement solely between the Trust on behalf of the Plan and Regence BlueShield of Idaho, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the Association), permitting the Claims Administrator to use the Blue Shield Service Mark in the state of Idaho and in Asotin and Garfield counties in the state of Washington and that the Claims Administrator is not contracting as the agent of the Association. The Trust on behalf of the Plan and its Claimants further acknowledges and agrees that it has not entered into the Agreement based upon representations by any person or entity other than Regence BlueShield of Idaho and that no person or entity other than Regence BlueShield of Idaho will be held accountable or liable to the Trust on behalf of the Plan or the Claimants for any of the Claims Administrator's obligations to the Trust on behalf of the Plan or the Claimants created under the Agreement. This paragraph will not create any additional obligations whatsoever on the part of Regence BlueShield of Idaho other than those obligations created under other provisions of the Agreement.

REPRESENTATIONS ARE NOT WARRANTIES

In the absence of fraud, all statements You make in an enrollment form will be considered representations and not warranties. No statement made for obtaining coverage will void such coverage or reduce benefits unless contained in a written document signed by You, a copy of which is furnished to You.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION AND MEDICAL RECORDS

It is important to understand that Your personal health information may be requested or disclosed by the Claims Administrator. This information will be used for the purpose of facilitating health care treatment, payment of claims or business operations necessary to administer health care benefits; or as required by law.

The information requested or disclosed may be related to treatment or services received from:

- an insurance carrier or group health plan;
- any other institution providing care, treatment, consultation, pharmaceuticals or supplies;
- a clinic, Hospital, long-term care or other medical facility; or
- a Physician, dentist, Pharmacist or other physical or behavioral health care Practitioner.

Health information requested or disclosed by the Claims Administrator may include, but is not limited to:

- billing statements;
- claim records;
- correspondence;
- dental records;
- diagnostic imaging reports;
- Hospital records (including nursing records and progress notes);
- laboratory reports; and
- medical records.

The Claims Administrator is required by law to protect Your personal health information, and must obtain prior written authorization from You to release information not related to routine health insurance operations. A Notice of Privacy Practices is available by visiting the Claims Administrator's website or contacting Customer Service.

You have the right to request, inspect and amend any records that the Claims Administrator has that contain Your personal health information. Contact the Claims Administrator's Customer Service to make this request.

NOTE: This provision does not apply to information regarding HIV/AIDS, psychotherapy notes, alcohol/drug services and genetic testing. A specific authorization will be obtained from You in order for the Claims Administrator to receive information related to these health conditions.

TAX TREATMENT

The Claims Administrator does not provide tax advice. Consult Your financial or tax advisor for information about the appropriate tax treatment of benefit payments and reimbursements.

WHEN BENEFITS ARE AVAILABLE

In order for health expenses to be covered, they must be incurred while coverage is in effect. Coverage is in effect when all of the following conditions are met:

- the person is eligible to be covered according to the eligibility provisions in the Plan; and
- the person has enrolled in coverage and has been enrolled by the Claims Administrator.

The expense of a service is incurred on the day the service is provided and the expense of a supply is incurred on the day the supply is delivered to You.

WOMEN'S HEALTH AND CANCER RIGHTS

If You are receiving benefits in connection with a mastectomy and You, in consultation with Your attending Physician, elect breast reconstruction, the Plan will provide coverage (subject to the same provisions as any other benefit) for:

- reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prosthesis and treatment of physical complications of all stages of mastectomy, including lymphedemas.

Definitions

The following are definitions of important terms, other terms are defined where they are first used.

Accidental Injury means an Injury sustained by a Claimant which is the direct result of an accident, independent of Illness or any other cause. Accidental Injury does not mean bodily Injury caused by routine or normal body movements such as stooping, twisting, bending or chewing and does not include any condition related to pregnancy.

Administrator means a person, if other than the trustee, employed or contracted by the trustee to provide administrative services to a self-funded plan.

Affiliate means a company with which the Claims Administrator has a relationship that allows access to Providers in the state in which the Affiliate serves and includes only the following companies: Regence BlueCross BlueShield of Oregon in the state of Oregon, Regence BlueCross BlueShield of Utah in the state of Utah and Regence BlueShield in parts of the state of Washington.

Allowed Amount means:

- For preferred and participating Providers, the amount that they have contractually agreed to accept as payment in full for Covered Services.
- For nonparticipating Providers who are not accessed through the BlueCard Program, the amount the Claims Administrator has determined to be reasonable charges or have negotiated for Covered Services. The Allowed Amount may be based upon billed charges for some services, as determined by the Claims Administrator or as otherwise required by law.
- For nonparticipating Providers accessed through the BlueCard Program, the lower of the Provider's billed charges and the amount that the Host Blue identifies to the Claims Administrator as the amount on which it would base a payment to that Provider. In exceptional circumstances, such as if the Host Blue does not identify an amount on which it would base payment, the Claims Administrator may substitute another payment basis.

Charges in excess of the Allowed Amount are not considered reasonable charges and are not reimbursable. For questions regarding the basis for determination of the Allowed Amount, contact the Claims Administrator's Customer Service.

Ambulatory Surgical Center means a distinct facility or that portion of a facility that operates exclusively to provide surgical services to patients who do not require hospitalization and for whom the expected duration of services does not exceed 24 hours following admission.

Beneficiary means a Participant's eligible dependent who is listed on the Participant's completed enrollment form and who is enrolled under the Plan.

Booklet means this booklet which provides a description of the benefits provided under the Plan. Plans with different benefit options may describe them in separate booklets for each alternative plan option.

Calendar Year means the period from January 1 through December 31 of the same year; however, the first Calendar Year begins on the Claimant's Effective Date.

Category 1 means the benefit cost-share level for services received from a Provider:

- that has an effective participating contract with the Claims Administrator, that designates the Provider as a preferred Provider, who is a member of the chosen Provider network, to provide services and supplies to Claimants in accordance with the provisions of this coverage;
- that has an effective participating contract with one of the Claims Administrator's Affiliates (designated as a "preferred" Provider), to provide services and supplies to Claimants in accordance with the provisions of this coverage; or
- outside the area that the Claims Administrator or one of its Affiliates serves, but who has contracted with another Blue Cross and/or Blue Shield organization in the BlueCard Program (designated as a

Provider in the "Preferred Provider Organization (PPO) Network"), to provide services and supplies to Claimants in accordance with the provisions of this coverage.

If the Claims Administrator or one of its Affiliates has more than one Provider network from which the Trust may choose for benefits under the Plan, then the Providers contracted with the network selected will be considered the only preferred Providers for purpose of payment of benefits. For Category 1 reimbursement, You will not be charged for balances beyond any Deductible, Copayment and/or Cost-Sharing for Covered Services.

Category 2 means the benefit cost-share level for services received from a Provider:

- that has an effective participating contract with the Claims Administrator, that designates the Provider as a participating Provider, who is a member of the chosen Provider network, to provide services and supplies to Claimants in accordance with the provisions of this coverage;
- that has an effective participating contract with one of the Claims Administrator's Affiliates (designated as a "participating" Provider), to provide services and supplies to Claimants in accordance with the provisions of this coverage; or
- outside the area that the Claims Administrator or one of its Affiliates serves, but who has contracted with another Blue Cross and/or Blue Shield organization in the BlueCard Program (designated as a Provider in the "Participating Network"), to provide services and supplies to Claimants in accordance with the provisions of this coverage.

For Category 2 reimbursement, You will not be charged for balances beyond any Deductible, Copayment and/or Cost-Sharing for Covered Services.

Category 3 means the benefit cost-share level for services received from a Provider that is not preferred or participating. For Category 3 services, You may be billed for balances over the Plan's payment level in addition to any Deductible, Copayment and/or Cost-Sharing amount for Covered Services provided inside or outside the area that the Claims Administrator or one of its Affiliates serves.

Claimant means a Participant or a Beneficiary.

Commercial Seller includes, but is not limited to, retailers, wholesalers or commercial vendors that are not Providers, who are approved to provide new medical supplies, equipment and devices in accordance with the provisions of this coverage.

Congenital Anomaly means a condition existing at or from birth that is a significant deviation from the common form or function of the body, whether caused by a hereditary or developmental defect or disease. "Significant deviation" means a deviation which impairs the function of the body and includes, but is not limited to:

- the conditions of cleft lip and/or cleft palate;
- webbed fingers or toes;
- sixth fingers or toes;
- defects of metabolism; or
- any other conditions that are medically diagnosed to be Congenital Anomalies.

Contribution means the amount paid or payable by the employer or employee, or a postsecondary educational institution or student, into the Trust Fund.

Cosmetic means services or supplies (including medications) that are provided primarily to improve or change appearance to normal structures of the body.

Covered Service means a service, supply, treatment or accommodation that is listed in the benefit sections in this Booklet.

Custodial Care means care for watching and protecting a patient, rather than being a Health Intervention. Custodial Care includes care that helps the patient conduct activities of daily living that can be provided

by a person without medical or paramedical skills and/or is primarily to separate the patient from others or prevent self-harm.

Dental Service means services or supplies (including medications) that are provided to prevent, diagnose or treat diseases or conditions of the teeth and adjacent supporting soft tissues, including treatment that restores the function of teeth.

Durable Medical Equipment means an item that can withstand repeated use, is primarily used to serve a medical purpose, is generally not useful to a person in the absence of Illness or Injury and is appropriate for use in the Claimant's home.

Effective Date means the date, following the Claims Administrator's receipt of the enrollment form, as the date coverage begins for You and/or Your Beneficiaries.

Emergency Medical Condition means a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson who has an average knowledge of medicine and health would reasonably expect the absence of immediate medical attention at a Hospital emergency room to result in any one of the following:

- placing the Claimant's health, or with respect to a pregnant Claimant, the Claimant's health or the health of the unborn child, in serious jeopardy;
- serious impairment to bodily functions; or
- serious dysfunction of any bodily organ or part.

Essential Benefits are determined by the U.S. Department of Health and Human Services (HHS) and are subject to change, but currently include at least the following general categories and the items and services covered within the categories:

- ambulatory patient services;
- emergency services;
- hospitalization;
- maternity and newborn care;
- mental health and substance use disorder services (including behavioral health treatment);
- prescription drugs;
- rehabilitative and habilitative services and devices;
- laboratory services;
- preventive and wellness services;
- chronic disease management; and
- pediatric services including oral and vision care.

Family means a Participant and any Beneficiaries.

Health Intervention is a medication, service or supply provided to prevent, diagnose, detect, treat or palliate the following:

- disease;
- Illness or Injury;
- genetic or Congenital Anomaly;
- pregnancy;
- biological or psychological condition that lies outside the range of normal, age-appropriate human variation; or
- to maintain or restore functional ability.

A Health Intervention is defined not only by the intervention itself, but also by the medical condition and patient indications for which it is being applied.

Health Outcome means an outcome that affects health status as measured by the length or quality of a person's life. The Health Intervention's overall beneficial effects on health must outweigh the overall harmful effects on health.

Hospital means a facility that is licensed as a general acute or specialty Hospital by the state in which the Hospital is located. A Hospital provides continuous 24-hour nursing services by registered nurses. A Hospital has an attending medical staff consisting of one or more Physicians. A Hospital per this definition is not, other than incidentally, a place for rest, a nursing home or a facility for convalescence.

Illness means a:

- congenital malformation that causes functional impairment;
- condition, disease, ailment or bodily disorder, other than an Injury; or
- pregnancy.

Illness does not include any state of mental health or mental disorder (which is otherwise defined).

Injury means physical damage to the body caused by:

- a foreign object;
- force;
- temperature;
- a corrosive chemical; or
- the direct result of an accident, independent of Illness or any other cause.

An Injury does not mean bodily Injury caused by routine or normal body movements such as stooping, twisting, bending or chewing and does not include any condition related to pregnancy.

Investigational means a Health Intervention that the Claims Administrator has classified as Investigational. The Claims Administrator will review Scientific Evidence from well-designed clinical studies found in peer-reviewed medical literature, if available, and information obtained from the treating Physician or Practitioner regarding the Health Intervention to determine if it is Investigational. A Health Intervention not meeting all of the following criteria is, in the Claims Administrator's judgment, Investigational:

- If a medication or device, the Health Intervention must have final approval from the FDA as being safe and effective for general marketing. However, if a medication is prescribed for other than its FDA-approved use and is recognized as effective for the use for a particular diagnosed condition, benefits for the medication may be provided when so used.
- The Scientific Evidence must permit conclusions concerning the effect of the Health Intervention on Health Outcomes, which include the disease process, Illness or Injury, length of life, ability to function and quality of life.
- The Health Intervention must improve net Health Outcome.
- Medications approved under the FDA's Accelerated Approval Pathway must show improved Health Outcomes.
- The Scientific Evidence must show that the Health Intervention is at least as beneficial as any established alternatives.
- The improvement must be attainable outside the laboratory or clinical research setting.

Lifetime means the entire length of time a Claimant is continuously covered under the Plan (which may include more than one coverage) through the Trust with the Claims Administrator.

Medically Necessary or Medical Necessity means health care services or supplies that a Physician or other health care Provider, exercising prudent clinical judgment, would provide to a patient to prevent, evaluate, diagnose or treat an Illness, Injury, disease or its symptoms, and that are:

- in accordance with generally accepted standards of medical practice. "Generally accepted standards of medical practice" means standards that are based on credible Scientific Evidence published in Peer-Reviewed Medical Literature generally recognized by the relevant medical community,

Physician Specialty Society recommendations and the views of Physicians and other health care Providers practicing in relevant clinical areas and any other relevant factors.

- clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's Illness, Injury or disease;
- not primarily for the convenience of the patient, Physician or other health care Provider; and
- not more costly than an alternative service or sequence of services or supply at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's Illness, Injury or disease.

Newborn Children means a child or children born during the term of the Agreement to a parent who is a Participant or spouse of a Participant. Newborn Children also includes adopted newborn infants who are Placed with the Participant within 60 days of the adopted child's date of birth. A child will no longer be a Newborn Child if they have a break in coverage of 63 or more days.

Newly Adopted Children means a child or children under the age of 18 who is Placed for adoption with a Participant more than 60 days after the child's date of birth. A child will no longer be a Newly Adopted Child if they have a break in coverage of 63 or more days after Placement for adoption with the Participant.

Participant means an Eligible Active Employee Participant or an Eligible Retiree Participant who has completed an enrollment form and is enrolled under this coverage.

Physician means an individual who is duly licensed to practice medicine and/or surgery in all of its branches or to practice as an osteopathic Physician and/or surgeon.

Placed or Placement means physical Placement in the care of the adoptive Participant. 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 Participant signs an agreement for adoption of such child and signs an agreement assuming financial responsibility for such child.

Plan Sponsor means any person who creates a self-funded health benefit plan for the benefit of any employer and employee or employees, or a postsecondary educational institution and student or students.

Practitioner means an individual who is duly licensed to provide medical or surgical services which are similar to those provided by Physicians. Practitioners include, but are not limited to:

- podiatrists;
- psychologists;
- certified nurse midwives;
- certified registered nurse anesthetists;
- dentists (doctor of medical dentistry, doctor of dental surgery, denturist, or a dental hygienist who is permitted by their respective state licensing board to independently bill third parties); and
- other professionals practicing within the scope of their respective licenses.

Primary Physician or Practitioner means a Physician, osteopathic Physician or Practitioner who, when acting within the scope of their state license, provides Your primary care or coordinates referral services when needed and is licensed in:

- general practice;
- family practice;
- internal medicine;
- pediatrics;
- geriatrics;
- obstetrics/gynecology (Ob/Gyn);
- preventive medicine;
- adult medicine; or
- women's health care.

Primary Physician or Practitioner also means any Physician assistant, nurse Practitioner or advanced registered nurse Practitioner licensed in one of the above specialties and working under a Physician, osteopathic Physician or Practitioner who is licensed in the same specialty.

Provider means:

- a Hospital;
- a Skilled Nursing Facility;
- an Ambulatory Surgical Center;
- a Physician;
- a Practitioner; or
- other individual or organization which is duly licensed to provide medical or surgical services.

Retail Clinic means a walk-in health clinic located within a retail operation and providing, on an ambulatory basis, preventive and primary care services. A Retail Clinic does not include:

- an office or independent clinic outside a retail operation;
- an Ambulatory Surgical Center;
- an urgent care center;
- a Hospital;
- a Pharmacy;
- a rehabilitation facility; or
- a Skilled Nursing Facility.

Scientific Evidence means scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff; or findings, studies or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes. However, Scientific Evidence shall not include published peer-reviewed literature sponsored to a significant extent by a pharmaceutical manufacturing company or medical device manufacturer or a single study without other supportable studies.

Self-Funded Plan means any single employer plan, public postsecondary educational institution plan, or multiple employer welfare plan, or any other single or multiple employer plan, or any postsecondary educational institution student health benefit plan, other than a plan providing only benefits under title 72, Idaho Code, under which payment for medical, surgical, Hospital, and other services for prevention, diagnosis, or treatment of any disease, Injury, or bodily condition of an 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 or employers, or by the employer or employers and the employees, or by a postsecondary educational institution and students at said institution, or students of a postsecondary educational institution, who are not otherwise covered by insurance or contract with a health care service corporation or managed care organization authorized to transact business in this state.

Skilled Nursing Facility means a facility or distinct part of a facility which is licensed by the state in which it is located as a nursing care facility and which provides skilled nursing services by or under the direction and supervision of a registered nurse.

Specialist means a Physician or Practitioner who does not otherwise meet the definition of a Primary Physician or Practitioner.

Trust Fund means a Trust Fund established in conjunction with a Self-Funded Plan for receipt of Contributions of employer and employees, postsecondary educational institution and students, and payment of or with respect to health care service costs of beneficiaries.

Trustee means the Trustee, whether a single or multiple Trustee, of the Trust Fund.

Appendix: Value-Added Services

This Plan includes access to the value-added services detailed in this Appendix. Services may be provided through third-party program partners who are solely responsible for their services. **THESE VALUE-ADDED SERVICES ARE VOLUNTARY, NOT INSURANCE AND ARE OFFERED IN ADDITION TO THE BENEFITS OF THIS BOOKLET.**

For additional information regarding any of these value-added services, visit the Claims Administrator's website or contact Customer Service. Contact information for value-added services for specific program partners is also included below, if applicable.

CARE MANAGEMENT

Receive one-on-one help and support in the event You have a chronic, serious or sudden Illness or Injury. An experienced care management nurse will serve as Your single point of contact and personal advocate to help You understand Your Providers' instructions, help prepare You for an elective surgical procedure, assist in coordinating overall care, connecting to special medical expertise and accessing other Plan Sponsor services and programs. Your nurse is supported by a multidisciplinary team made up of doctors, social workers, Pharmacists and behavioral health experts that can be accessed for additional consultation. The goal is to offer assistance in navigating through Your health care needs, including working with Your community resources to provide a personalized touch and to enhance the quality of Your wellbeing. Care management nurses proactively outreach by telephone and educational mailings or You may request support by directly contacting a nurse. To learn more, call 1 (866) 543-5765.

NURSE ADVICE

You have access to registered nurses to answer Your health-related questions or concerns and to help You make informed decisions on seeking the appropriate level of care (whether to seek care in an emergency room, urgent care, office visit or self-care at home). This service is available to You on an unlimited basis at no additional cost. However, if You are experiencing a medical emergency, immediately call 911 instead.

PREGNANCY PROGRAM

Pregnancy is a time of planning and excitement, but it can also be a time of confusion and questions. The Pregnancy Program can provide answers and assistance so that You can relax and enjoy those nine life-changing months.

If You are expecting a child, this program offers access to a nurse 24 hours a day, 7 days a week and educational materials tailored to Your needs. Since the Pregnancy Program is most beneficial when You enroll early in a pregnancy, call 1 (888) JOY-BABY (569-2229) or visit the Claims Administrator's website right away to get started.

REGENCE EMPOWER

Regence Empower is a well-being program that offers a range of tools, information and support for a healthy lifestyle. It may include the following:

- earning up to $25 in gift cards for completion of well-being activities such as an online health risk assessment;
- incentives to reward participation in healthy activities; and
- online tools that integrate with fitness apps and devices to track progress toward Your health and well-being goals.

Plan Description

The Plan is a self-funded health care plan regulated by the Idaho Department of Insurance pursuant to Chapter 40, Title 41, Idaho Code. Note that the terms "You" and "Your" in this Plan Description Section by and large refer to the Participant.

PLAN NAME
Boise Fire & Police Trust ERHC Plan

NAME, ADDRESS AND PHONE NUMBER OF THE TRUST
Boise Fire & Police Trust
c/o Vimly Benefit Solutions, Inc.
12121 Harbour Reach Dr., Ste. 105
Mukilteo, WA 98275
1 (206) 859-2608

EMPLOYER IDENTIFICATION NUMBER ASSIGNED FOR THIS PLAN BY THE IRS
27-6863381

REGENCE GROUP NUMBER
10017672

TYPE OF PLAN
Welfare Benefit Plan: medical and prescription medication benefits

TYPE OF ADMINISTRATION
For the processing of claims for medical benefits under the terms of the Plan, the Trust has contracted with Regence BlueShield of Idaho, which is referred herein as the Claims Administrator. For the processing of claims for prescription medication benefits under the terms of the Plan, the Trust has contracted with Sav-Rx, which is referred to herein as the PBM (pharmacy benefit manager). Finally, to assist with other day-to-day administrative matters, the Trust has contracted with Vimly Benefit Solutions, Inc., a third-party Administrator.

RIGHT TO ADMINISTER AND INTERPRET THE PLAN
The Trust through the Trustees has the full and complete authority, responsibility, discretion, and control over the management, administration, and operation of the Plan, including but not limited to the discretion to formulate, adopt, issue, and apply procedures and rules and change, alter, or amend such procedures and rules in accordance with the law, to interpret and apply the provisions of the Plan, and to make appropriate determinations concerning the availability of, and eligibility for, benefits. Subject to Your rights explained in the "Appeal Process" section, the Trust's determinations shall be final, conclusive, and binding on all parties. The Claims Administrator and Sav-Rx Prescription Services are also granted such deferential interpretative authority relative to their responsibilities in determining claims and appeals under the Plan.

NAME, ADDRESS AND PHONE NUMBER OF THIRD-PARTY ADMINISTRATOR
Attn: Suzan Kolb
Vimly Benefit Solutions, Inc.
12121 Harbour Reach Dr., Ste. 105
Mukilteo, WA 98275
1 (206) 859-2608

SOURCES OF CONTRIBUTIONS TO THE PLAN
Contributions for Plan expenses are obtained from the City of Boise and Participants.

FUNDING MEDIUM
Benefits provided pursuant to the Plan are funded through the Boise Fire & Police Trust.

PLAN YEAR

January 1 – December 31

PLAN TERMINATION PROVISIONS

The Plan Sponsor and Trust expect and intend to continue the Plan indefinitely, but reserves its right to end the Plan at any time in its sole discretion. The Trust also reserves the right to amend the Plan at any time in its sole discretion.

The decision to terminate or amend the Plan may be due to changes in federal or state laws governing welfare benefits or for any other reason. If the Plan Sponsor or Trust does change or end the Plan, it may decide to set up a different plan providing similar or identical benefits.

If the Plan is terminated, plan Participants and Beneficiaries will not have any further rights. The amount and form of any final benefit will depend on any contract provisions affecting the Plan, and the Trust's decisions.

APPENDIX 1

Section 1 of this Appendix describes the scope of services available to You and Your eligible Family Members at no out-of-pocket cost to You under the capitated care portion of Your ERHC Plan. Section 2 lists some of the regular services outside of the capitated care arrangement with ERHC. All claims for benefits not listed in Section 1 will be administered by Regence and will be subject to the schedule of benefits set forth in the Plan Booklet. Section 3 sets out the days and hours of operation of the ERHC Clinic and Section 4 describes the Claims and Appeal Process applicable to the capitated care portion (Section 1, below) of the Plan. The Claims and Appeal Process that applies to claims administered by Regence is described in the Claims Administration and Appeal Process sections of the Plan Booklet.

1. **Medical Services Provided at No Out-of-Pocket Cost to Members.** ERHC will provide the medical services listed and generally described below to active employee members and their eligible family members enrolled in the ERHC Plan at no out-of-pocket cost to members.

   a. Primary Care

   - Annual Wellness Exams & Comprehensive Health Assessments
   - Cancer Screening
   - Computerized Vision & Hearing Screening
   - Personal Health Planning/Behavioral & Lifestyle Management
   - Nutrition, Health & Fitness Counseling (weight loss, diet, personal goal setting)
   - Chronic Disease Management, including Asthma Treatment, Diabetes Monitoring
   - Depression & Anxiety Screening
   - Lesion Assessment & Treatment/Removal
   - Physical Therapy Services

   b. Pediatric & Adolescent Health

   - Annual Well Child Exams
   - Sports Physicals (as required for participation in athletics)
   - Infant Circumcision (male)

   c. Urgent Care

   - Assessment/Treatment of Minor Illnesses & Injury
   - Sore Throats, Respiratory Complaints, Nebulizer Treatments, Gastrointestinal or Abdominal Complaints
   - Wounds, Lacerations, Fractures, Sprains (Casting & Splints)
   - Musculoskeletal Pain – Back and Joint Pain

   d. Urgent Care Pharmacy Benefit

   - Approximately 50 different formulations of most common urgent care prescriptions (antibiotics & antivirals, allergy & asthma, analgesics/NSAIDs, muscle relaxants, steroids, topicals, and more).

   e. Women's and Men's Health

   - Annual Wellness Exams
   - Pap Smears, Pelvic Exams, Clinical Breast Exams, Prostate Cancer Screenings

- Family Planning, Pre-Conception Health, Contraception & early Pre-natal Care, Vasectomies
- STD Screening & Treatment

f. Heart & Lung Health

- Cardiology Screening & Referrals – EKG, Treadmill Stress Testing
- Spirometry Tests (lung function)

g. Occupational Health

- Occupational Risk Counseling
- Sports Medicine Consultation
- Workers Compensation Care (covered by WC agencies)
- Functional Movement Screening & Injury Prevention Assessment
- CDL License Examination & Certification

h. Dermatology

- Annual Dermatologic Screening
- Mole & Lesion Assessment/Excision
- Lipomas & Epidermal Inclusion Cyst Excision
- Lacerations

i. Mental Health Services

- Outpatient Mental Health Therapy (adults; couples)
- PTSI Treatment/Assistance with Workers' Compensation Claims for PTSI/PTSD
- Pharmacotherapy Management (most mental health conditions)

j. Orthopedics

- Outpatient Fracture Care (non-operative)
- Joint Injections (most therapies)
- Orthopedic Braces (standard/non-customized)

k. Physical Therapy

- Physical Therapy Rehabilitation (Acute & Chronic Conditions, Post-Operative Care)
- Myofascial Release Soft Tissue & Joint Mobilization (IASTM)
- Strength & Conditioning

l. Nutrition and Body Composition

- Consultation with Registered Dietitian Nutritionist (RDN)
- Medical nutrition therapy and wellness counseling
- Weight management counseling
- InBody 770 body composition analysis

m. Diagnostic Services

- Laboratory – Phlebotomy (blood draws), Wellness Labs (CBC, metabolic profile, fasting lipids, uric acid, TSH, HgbA1c, PSA), Infectious disease screening (HIV, Hepatitis C Ab and Hepatitis B Ab titer), in-house Labs (rapid strep, influenza swab, mononucleosis testing, urinalysis, urine pregnancy and fasting blood glucose) and specimen analysis by external pathology laboratories needed to follow up in-house urine screening and rapid strep testing.
- Imaging – digital X-ray including radiology interpretation

n. Immunizations

- Seasonal flu, Hepatitis A (2-shot series), Hepatitis B (3-shot series), Tdap (tetanus, diphtheria, pertussis), MMR (mumps, measles, rubella), all pediatric vaccinations as covered by the State of Idaho

2. Medical Services Subject to the ERHC Plan Schedule of Benefits. Medical services covered by the ERHC Plan but not included within the scope of Section 1, above, are subject to the ERHC Plan's schedule of benefits. Medical services subject to the ERHC Plan's schedule of benefits include, but are not limited to:

- Hospital Admissions
- Medical Specialists
- Immunizations, such as the shingles vaccine, not included in Section A.1.h., above
- Special order clinical supplies, such as IUD contraception, visco-supplementation for joint pain, and custom braces
- Custom Orthopedic and Orthotic supplies
- Specimen analysis by external pathology laboratories, other than external specimen analysis needed to follow up in-house urine screening and rapid strep testing
- Specimen analysis by external pathology laboratories
- Prescription medications dispensed by off-site pharmacies

In the event ERHC provides a medical service outside the scope of Section 1 to an enrollee of the ERHC Plan, such service shall be subject to the ERHC Plan's schedule of benefits and ERHC will submit an invoice for payment to Regence.

3. Service Scheduling.

a. ERHC's Clinic at 9976 West Emerald Street, Boise, Idaho will be open and available for ERHC Plan enrollees Monday – Thursday from 8:00 a.m. until 6:00 p.m., Friday from 8:00 a.m. until 5:00 p.m., and Saturday from 10:00 a.m. until 2:00 p.m. ERHC will be closed for the following holidays: New Year's Day; July 4th; Thanksgiving Day; December 24th; and Christmas Day.

b. ERHC will provide same or next day appointments for urgent care when requested by EHRC-Preferred Plan enrollees.

4. Claims and Appeal Process.

ERHC Plan enrollees are encouraged (but not required) to work with ERHC directly to informally resolve any disputes prior to engaging in the process set forth below.

In the event ERHC declines to provide You or Your eligible Family Member a requested medical service you believe to be within the scope of the capitated care services set forth in Section 1, above, You will be provided with a notice of the claim denial and of Your right to appeal. Following your receipt of that notice, You or Your Representative (any Representative authorized by You) may Appeal to the Board of Trustees in accordance with the time frames and process set forth in that notice, and summarized below.

Appeals to the Board of Trustees can be initiated through either written or verbal request. A written request can be made by: sending it to Board of Trustees, c/o Vimly Benefit Solutions, Inc., 12121 Harbour Reach Dr., Ste. 105, Mukilteo, WA 98275; faxing it to 1 (866) 676-1530: or emailing it to bfpt@vimly.com, provided that verbal requests for Appeals to the Board of Trustees involving an Expedited Appeal can also be made by calling Vimly Benefit Solutions, Inc. at 1 (206) 859-2608.

Appeals to the Board of Trustees, including Expedited Appeals, must be pursued within 180 days of Your receipt of the notice of claim denial. You, or Your Representative on Your behalf, will be given a reasonable opportunity to provide written materials. If You don't Appeal within this time period, You will not be able to continue to pursue the Appeal process and may jeopardize Your ability to pursue the matter in any forum.

If You or Your treating Provider determines that Your health could be jeopardized by waiting for a Pre-Service or concurrent claim decision under the regular Appeal process, You or Your treating Provider may specifically request an Expedited Appeal. Please see Expedited Appeals later in this section for more information.

Appeals are reviewed by the Board of Trustees, who were not involved with ERHC's decision that You are Appealing. In Appeals that involve issues requiring medical judgment, the Trustees will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgement. For Post-Service Appeals, a written notice of the decision will be sent within 30 days of receipt of the Appeal. For Appeals involving a Pre-Service claim, the Trustees will send a written notice of the decision within 14 days of receipt of the Appeal. For Post-Service Appeals, the Claims Administrator will send a written notice of the decision within 20 working days of receipt of the Appeal.

An expedited Appeal is available if one of the following applies:

- the application of regular Appeal timeframes on a Pre-Service or concurrent care claim either:
    - could jeopardize Your life, health or ability to regain maximum function; or
    - according to a Provider with knowledge of Your medical condition, would subject You to severe pain that cannot be adequately managed without the disputed care or treatment; or
    - the treatment would be significantly less effective if not promptly initiated.

The Expedited Appeal request should state the need for a decision on an expedited basis and must include documentation necessary for the Appeal decision. Verbal notice of the decision will be provided to You and Your Representative as soon as possible after the decision, but no later than 72 hours of receipt of the Appeal. This will be followed by written notification within three working days of the verbal notice.

YOUR RIGHT TO AN INDEPENDENT EXTERNAL REVIEW
Please read this notice carefully. It describes a procedure for review of a disputed health claim by a qualified professional who has no affiliation with your health plan. If You request an independent external review of Your claim, the decision made by the independent reviewer will be binding and final on the Plan.

If the Trustees issue a final adverse benefit determination of Your request to provide or pay for a health care service or supply that is a Covered Service in Section 1 of Appendix 1 of this Booklet, You may have the right to have the Trustees' decision reviewed by health care professionals who have no association with the Plan. You have this right only if the Trustees' denial decision involved:

- the Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of Your health care service or supply; or
- the Trustees' determination that Your health care service or supply was Investigational.

You must first exhaust the Plan's internal grievance and Appeal process. Exhaustion of that process includes completing all levels of Appeal, or unless You requested or agreed to a delay, the Trustees' failure to respond to a standard Appeal within 35 days in writing or to an urgent Appeal within three working days of the date You filed Your Appeal. The Trustees may also agree to waive the exhaustion requirement for an external review request. You may file for an expedited Appeal with the Trustees and for an expedited external review with the Idaho

Department of Insurance at the same time if Your request qualifies as an urgent care request, as defined under the Expedited External Review Request provision below.

You may submit a written request for an external review to:

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

For more information and for an external review request form see the department's website at **www.doi.idaho.gov**, or call the department's telephone number at 1 (208) 334-4250 or toll-free in Idaho at 1 (800) 721-3272.

You may represent Yourself in Your request or You may name another person, including Your treating health care Provider, to act as Your authorized representative for Your request. If You want someone else to represent You, You must include a signed "Appointment of an Authorized Representative" form with Your request.

Your written external review request to the Department of Insurance must include a completed form authorizing the release of any of Your medical records the Independent Review Organization (IRO) may require to reach a decision on the external review, including any judicial review of the external review decision pursuant to ERISA, if applicable. The department will not act on an external review request without Your completed authorization form.

If Your request qualifies for external review, the Trustees' final adverse benefit determination will be reviewed by an IRO selected by the department. The Plan pays the costs of the review.

Standard External Review Request: You must file Your written external review request with the Department of Insurance within four months after the date the Trustees issue a final notice of denial.

- Within seven days after the department receives Your request, the department will send a copy to the Trustees.
- Within 14 days after the Trustees receive Your request from the department, the Trustees will review Your request for eligibility. Within five working days after the Trustees complete that review, the Trustees will notify You and the department in writing whether Your request is eligible or what additional information is needed. If the Trustees deny Your eligibility for review, You may Appeal that determination to the department.
- If Your request is eligible for review, the department will assign an IRO to Your review within seven days of the receipt of the Trustees' notice. The department will also notify You in writing.
- Within seven days of the date You receive the department's notice of assignment to an IRO, You may submit any additional information in writing to the IRO that You want the IRO to consider in its review.
- The IRO must provide written notice of its decision to You, to the Trustees and to the department within 42 days after receipt of an external review request.

Expedited External Review Request
You may file a written urgent care request with the Department of Insurance for an expedited external review of a Pre-Service or concurrent service denial. You may file for an expedited Appeal with the Trustees and for an expedited external review request with the department 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 You received emergency services but have not been discharged from a facility, or any Pre-Service or concurrent care claim for medical care or treatment for which application of the time periods for making a regular external review determination:

- could seriously jeopardize Your life or health or ability to regain maximum function;
- in the opinion of the treating health care professional with knowledge of Your medical condition, would subject You to severe pain that cannot be adequately managed without the disputed care or treatment; or
- the treatment would be significantly less effective if not promptly initiated.

The department will send Your expedited external review request to the Trustees, who will determine, no later than the second full working day, whether Your request is eligible for review. The Trustees will notify You and the department no later than one working day after the decision if Your request is eligible. If the Trustees deny Your eligibility for review, You may Appeal that determination to the department.

If Your request is eligible for review, the department will assign an IRO to Your review upon receipt of the Trustees' notice. The department will also notify You. The IRO must provide notice of its decision to You, to the Trustees and to the department within 72 hours after the date of receipt of the external review request. The IRO must provide written confirmation of its decision within 48 hours of notice of its decision. If the decision reverses the Trustees' denial, the Trustees will notify You and the department of the intent to pay the covered benefit as soon as reasonably practicable, but not later than one working day after receiving notice of the decision.

Binding Nature Of The External Review Decision
The external review decision by the IRO will be final and binding on both You and the Plan. **This means that if You elect to request external review of Your claim, You will be bound by the decision of the IRO. You will not have any further opportunity for review of Your claim after the IRO issues its final decision.** If You choose 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 IRO is immune from any legal action against it based upon the opinion rendered by the IRO or acts or omissions performed within the scope of its duties unless performed in bad faith or involving gross negligence.

INFORMATION
If You have any questions about the Appeal Process outlined here, You may contact the Trust's third-party-administrator, Vimly Benefit Solutions, Inc., at: 12121 Harbour Reach Dr., Ste. 105, Mukilteo, WA 98275; fax 1 (866) 676-1530; email bfpt@vimly.com; or by calling 1 (206) 859-2608.

Your Prescription Medication Benefits Administered by Sav-Rx

Your prescription drug coverage is administered through Sav-Rx. Sav-Rx does not provide BlueCross BlueShield Services and is a separate company solely responsible for its products and services. Regence BlueShield of Idaho assumes no liability for the accuracy of Your prescription drug benefits information. Please visit Sav-Rx's website at www.savrx.com or contact Sav-Rx's Customer Service at 1 (800) 228-3108 if You have questions.

In this section, You will learn how Your Prescription Medication coverage works, including information about Deductibles (if any), Copayments, Cost-Sharing, Covered Services and payment, as well as definitions of terms specific to this Prescription Medication Benefits Section.

All terms and conditions of the Plan apply to this Prescription Medication Benefits Section, except as otherwise noted. Benefits will be paid under this Prescription Medication Benefits Section, not any other provision in this Booklet, if a medication or supply is covered under both.

PRESCRIPTION MEDICATION CALENDAR YEAR DEDUCTIBLES

Not applicable

COPAYMENTS AND COST-SHARING

After You meet any applicable Deductible, You are responsible for paying the following Copayment and/or Cost-Sharing amounts (at the time of purchase, if the Pharmacy submits the claim electronically). See below for information on claims that are not submitted electronically and for information on maximum quantities.

For Prescription Medications from a Pharmacy

- $5 for each Generic Medication (per 90-day supply)
- $12 for each Brand-Name Medication on the Formulary (per 90-day supply)
- $35 for each Brand-Name Medication not on the Formulary (per 90-day supply)

For Prescription Medications from a Mail-Order Supplier

- $5 for each Generic Medication
- 20% up to $50 for each Brand-Name Medication on the Formulary
- 20% up to $50 for each Brand-Name Medication not on the Formulary

For Prescription Medications from a Specialty Pharmacy

- The same Copayment and/or Cost-Sharing listed above for Prescription Medications from a Pharmacy apply to Specialty Medications obtained from a Specialty Pharmacy. The first fill is allowed at a Pharmacy. Additional fills must be provided at a Specialty Pharmacy.

Brand-Name Prescription Medication Instead of Generic

If an equivalent Generic Medication is available and You choose to fill a Prescription Order with a Brand-Name Medication, You will be responsible for paying the difference in cost (which does not count toward Your Deductible (if applicable) or any Out-of-Pocket Maximum). The difference is calculated at the time of purchase based upon the difference in price between the equivalent Generic Medication and the applicable Brand-Name Medication, in addition to the Copayment and/or Cost-Share (as applicable). The exception is when the prescribing Provider specifies that the Brand-Name Medication must be dispensed, in which case You will not be responsible for payment of the difference in cost.

YOUR ELIGIBLE PRESCRIPTION DRUG COPAYS ACCUMULATE TOWARD YOUR PLAN'S MEDICAL OUT-OF-POCKET MAXIMUM. PLEASE REFER TO "MEDICAL BENEFITS" IN THE BEGINNING OF THIS BOOKLET FOR MORE INFORMATION ON YOUR OUT-OF-POCKET.

COVERED PRESCRIPTION MEDICATIONS

Benefits under this Prescription Medication Benefits Section are available for the following:

- Diabetic supplies (including test strips, glucagon emergency kits, insulin and insulin syringes, but not insulin pumps and their supplies), when obtained with a Prescription Order (insulin pumps and their supplies are covered under the Durable Medical Equipment benefit);
- Syringes and needles purchased within 90 days of insulin purchase do not require a separate Copayment. All other diabetic supplies covered under this Prescription Medication Benefits Section will be subject to Brand-Name Medication Copayments;
- Oral impotence medications, limited to eight pills per month, 24 pills per rolling 90 days;
- Prescription Medications;
- Certain preventive medications (including, but not limited to, statins, aspirin, fluoride, iron and Generic Medications for tobacco use cessation) according to, and as recommended by, the USPSTF, when obtained with a Prescription Order;
- FDA-approved women's prescription and over-the-counter (if presented with a prescription) contraception methods as recommended by the HRSA. These include female condoms, diaphragm with spermicide, sponge with spermicide, cervical cap with spermicide, spermicide, oral contraceptives (combined pill, mini pill and extended/continuous use pill), contraceptive patch, vaginal ring, contraceptive shot/injection and emergency contraceptives (both levonorgestrel- and ulipristal acetate-containing products);
- Immunizations for adults and children according to, and as recommended by, the CDC;
- Specialty Medications (one fill at a Pharmacy, then all Specialty Medications are required to be filled at a Specialty Pharmacy); and
- Self-Administrable Prescription Medications (including, but not limited to, Self-Administrable Compound and Injectable Medications).

You are not responsible for any applicable Deductible, Copayment and/or Cost-Sharing when You fill prescriptions at a Participating Pharmacy for specific strengths or quantities of medications that are specifically designated as preventive medications, women's contraceptives, or for immunizations, as specified above. NOTE: The applicable Deductible, Copayment and/or Cost-Sharing as listed in this Prescription Medication Benefits Section will apply when You fill preventive medications and immunizations that meet the above criteria, at a Nonparticipating Pharmacy. For a list of such medications, please visit the PBM's website at **www.savrx.com** or contact the PBM's Customer Service at 1 (800) 228-3108. Also, if your Provider believes that the PBM's covered preventive medications, including women's contraceptives, are medically inappropriate for You, You may request a coverage exception for a different preventive medication by contacting Customer Service at this same number.

The Plan will cover only Medically Necessary prescription drugs that have been approved by the United States Food and Drug Administration (FDA) and prescribed by a licensed Physician. The fact that a Physician may prescribe, order, recommend or approve of a particular prescription does not guarantee coverage under this Plan.

You may seek prior authorization for a particular drug by asking your Physician to submit a request to Sav-Rx prior to dispensing the drug. Sav-Rx will determine if a particular drug is Medically Necessary, and thus, covered under this Plan.

A drug will only be considered Medically Necessary if it meets the following requirements (in addition to the definition of Medical Necessity in the Regence portion of this Plan document), it:

- Is essential and appropriate for the diagnosis or treatment of an Illness or Injury;
- Is regarded as safe and effective by most Physicians in the United States; and

- Is the most appropriate and economical prescription drug available.

GENERAL PRESCRIPTION MEDICATION BENEFITS INFORMATION (NETWORK, SUBMISSION OF CLAIMS AND MAIL-ORDER)

A nationwide network of Participating Pharmacies is available to You. Pharmacies that participate in this network submit claims electronically.

Your Plan identification card enables You to participate in this Prescription Medication program, so You must use it to identify Yourself at any Pharmacy. If You do not identify Yourself as a Claimant through Sav-Rx, a Participating Pharmacy or Mail-Order Supplier may charge You more than the Covered Prescription Medication Expense. You can find Participating Pharmacies and a Pharmacy locator on the PBM's website at **www.savrx.com** or by contacting Customer Service at 1 (800) 228-3108.

Claims Submitted Electronically

You must present Your Plan identification card at a Pharmacy for the claim to be submitted electronically. You must pay any required Deductible, Copayment and/or Cost-Sharing at the time of purchase. If a Nonparticipating Pharmacy provides Your Prescription Medication and submits the claim electronically, the Nonparticipating Pharmacy will be paid directly. Nonparticipating Pharmacies, however, may charge amounts in excess of Covered Prescription Medication Expenses. If that happens, You will be responsible for the excess amounts, as well as any Deductible, Copayment and/or Cost-Sharing shown electronically to the Nonparticipating Pharmacy at the time of purchase.

Claims Not Submitted Electronically

When a claim is not submitted electronically, You must pay for the Prescription Medication in full at the time of purchase. For reimbursement, simply complete a Prescription Medication Reimbursement claim form and mail the form and receipt to the Sav-Rx. You will be reimbursed based on the Covered Prescription

Medication Expense, less the applicable Deductible, Copayment and/or Cost-Sharing that would have been required had the medication been purchased from and submitted electronically by a Participating Pharmacy. Payment will be sent directly to You.

It is best to use a Participating Pharmacy so Your claims can be submitted electronically, and so You won't have to pay the difference between the Pharmacy's charges and the Covered Prescription Medication Expense in addition to Your Deductible, Copayment and/or Cost-Sharing.

Mail-Order

You can also use mail-order services to purchase covered Prescription Medications. Mail-order coverage applies only when Prescription Medications are purchased from a Mail-Order Supplier and the claim is submitted electronically. Not all Prescription Medications are available from Mail-Order Suppliers.

To buy Prescription Medications through the mail, simply send all of the following items to a Mail-Order Supplier at the following address: Sav-Rx Mail Order Pharmacy, P.O. Box 8, Fremont, NE 68026.

- A completed prescription mail-order form, available on the PBM's website at www.savrx.com or from the Trust (which also includes refill instructions);
- Any Deductible, Copayment and/or Cost-Sharing; and
- The original Prescription Order.

PREAUTHORIZATION

Preauthorization may be required to establish that a Prescription Medication is Medically Necessary before it is dispensed. The PBM publishes a list of those medications that currently require preauthorization. You can see the list on their website at **www.savrx.com**, or call Customer Service at 1 (800) 228-3108. In addition, participating Providers, including Pharmacies, are notified which Prescription Medications require preauthorization. The prescribing Provider must provide the medical information necessary to determine Medical Necessity of Prescription Medications that require preauthorization.

Coverage for preauthorized Prescribed Medications begins on the date the PBM preauthorizes them. If Your Prescription Medication requires preauthorization and You purchase it before the PBM preauthorizes it or without obtaining the preauthorization, the Prescription Medication may not be covered, even if purchased from a Participating Pharmacy.

LIMITATIONS

The following limitations apply to this Prescription Medication Benefits Section, except for certain preventive medications as specified in the Covered Prescription Medications Section:

Maximum 30-Day or Greater Supply Limit

- **Injectable Medications and 30-Day Supply.** The largest allowable quantity for Self-Administrable Injectable Medications purchased from a Pharmacy or Mail-Order Supplier is a 30-day supply. The Copayment and/or Cost-Sharing for Self-Administrable Injectable Medications purchased from a Mail-Order Supplier will be the same as if the medication was purchased from and the claim was submitted electronically by a Pharmacy.
- **Specialty Medications and 30-Day Supply.** The largest allowable quantity for a Specialty Medication purchased from a Specialty Pharmacy, is a 30-day supply. For Specialty Medications to be covered after the initial fill, they must be filled at the Sav-Rx Specialty Pharmacy. The address of the Sav-Rx Specialty Pharmacy is:

  Sav-Rx Specialty Pharmacy
  P.O. Box 8
  Fremont, NE 68026

- **Mail-Order and 90-Day Supply.** The largest allowable quantity of a Prescription Medication purchased from a Mail-Order Supplier is a 90-day supply. A Provider may choose to prescribe or You may choose to purchase, some medications in smaller quantities. Self-Administrable Injectable Medications are limited to a 30-day supply as indicated above.
- **Pharmacy and 90-Day Supply.** The largest allowable quantity of a Prescription Medication purchased from a Pharmacy is a 90-day supply. A Provider may choose to prescribe or You may choose to purchase, some medications in smaller quantities.
- **Pharmacy and 90-Day Multiple-Month Supply.** The largest allowable quantity of a covered Prescription Medication that is packaged exclusively in a multiple-month supply and is purchased from a participating retail maintenance Pharmacy is the smallest multiple-month supply packaged by the manufacturer for dispensing by Pharmacies. The availability of that supply at a given Pharmacy or time is not a factor in identifying the smallest multiple-month supply. The maximum supply covered for these products is a 90-day supply (even if the packaging includes a larger supply). The Copayment and/or Cost-Sharing is based on each 30-day supply within that multiple-month supply.

Maximum Quantity Limit

For certain Prescription Medications, the PBM establishes maximum quantities other than those described previously. This means that, for those medications, there is a limit on the amount of medication that will be covered during a period of time. The PBM uses information from the FDA and from scientific publications to establish these maximum quantities. When You take a Prescription Order to a Participating Pharmacy or request a Prescription Medication refill and use Your Plan identification card, the Pharmacy will let You know if a quantity limitation applies to the medication.

You may also find out if a limit applies by contacting Sav-Rx Customer Service at 1 (800) 228-3108. The Plan does not cover any amount over the established maximum quantity, except if it is determined the amount is Medically Necessary. The prescribing Provider must provide medical information in order to establish whether the amount in excess of the established maximum quantity is Medically Necessary.

Refills

The Plan will cover refills from a Pharmacy when You have taken 75 percent of the previous prescription. Refills obtained from a Mail-Order Supplier are allowed after You have taken all but 20 days of the previous Prescription Order. If You choose to refill Your Prescription Medications sooner, You will be responsible for the full costs of these Prescription Medications and these costs will not count toward Your

Deductible (if applicable) or any Out-of-Pocket Maximum. If You feel You need a refill sooner than allowed, a refill exception will be considered at the PBM's discretion on a case-by-case basis. You may request an exception by calling Sav-Rx Customer Service at 1 (800) 228-3108.

Prescription Medications Dispensed by Excluded Pharmacies
A Pharmacy may be excluded if it has been investigated by the Office of the Inspector General (OIG) and appears on the OIG's exclusion list. If You are receiving medications from a Pharmacy that is later determined by the OIG to be an excluded Pharmacy, You will be notified, after Your claim has been processed, that the Pharmacy has been excluded, so that You may obtain future Prescription Medications from a non-excluded Pharmacy. Excluded Pharmacies are not permitted to submit claims after the excluded Pharmacies have been added to the OIG list.

EXCLUSIONS
In addition to the exclusions in the General Exclusions Section, the following exclusions apply to this Prescription Medication Benefits Section, unless specifically defined by the PBM:

Acne Medication
Prescription Medications for the treatment of acne in Claimants over age 38. Coverage for acne medications for Claimants age 39 or older may otherwise be provided with Prior Authorization.

Biological Sera, Blood or Blood Plasma

Certain Compound Medications
Compound Medications that do not contain at least one Prescription Medication or that contain any ingredient or bulk chemical that is excluded or otherwise not covered by the Plan.

Cosmetic Purposes
Prescription Medications used for cosmetic purposes, including, but not limited to: removal, inhibition or stimulation of hair growth; retardation of aging; or repair of sun-damaged skin.

Devices or Appliances
Devices or appliances of any type, even if they require a Prescription Order (coverage for devices and appliances may otherwise be provided under the Medical Benefits Section).

Foreign Prescription Medications
Except for Prescription Medications associated with an Emergency Medical Condition while You are traveling outside the United States, or Prescription Medications You purchase while residing outside the United States, the Plan does not cover foreign Prescription Medications. These exceptions apply only to medications with an equivalent FDA-approved Prescription Medication that would be covered under this section if obtained in the United States.

Insulin Pumps and Pump Administration Supplies
Coverage for insulin pumps and supplies is provided under the Medical Benefits Section.

Medications That Are Not Considered Self-Administrable
Coverage for these medications may otherwise be provided under the Medical Benefits Section.

Nonprescription Medications
Medications that by law do not require a Prescription Order and which are not included in the Claims Administrator's definition of Prescription Medications, shown below, unless included on the Formulary.

PCSK9 Medications

Prescription Medications Dispensed in a Facility
Prescription Medications dispensed to You while You are a patient in a Hospital, Skilled Nursing Facility, nursing home or other health care institution. Medications dispensed upon discharge should be processed under this benefit if obtained from a Pharmacy.

Prescription Medications for Treatment of Infertility
Notwithstanding this exclusion, the Trust offers Eligible Participants a fertility benefit solution through Progyny, Inc. outside of the benefits described in this Booklet. Please contact Progyny for more information at 1 (866) 960-3691 or refer to the Fertility and Family Building Benefit Member Guide, which is available on the Vimly Benefits Solutions, Inc. SIMON portal at bfpt.simon365.com or by contacting the Trust Office at 1 (206) 859-2608 or bfpt@vimly.com.

Prescription Medications Not Dispensed by a Pharmacy Pursuant to a Prescription Order

Prescription Medications Not within a Provider's License
Prescription Medications prescribed by Providers who are not licensed to prescribe medications (or that particular medication) or who have a restricted professional practice license.

Prescription Medications without Examination
The Plan does not cover prescriptions made by a Provider without recent and relevant in-person examination of the patient, whether the Prescription Order is provided by mail, telephone, internet or some other means. For purposes of this exclusion, an examination is "recent" if it occurred within 12 months of the date of the Prescription Order and is "relevant" if it involved the diagnosis, treatment or evaluation of the same or a related condition for which the Prescription Medication is being prescribed.

Professional Charges for Administration of Any Medication

DEFINITIONS
In addition to the definitions in the Definitions Section, the following definitions apply to this Prescription Medication Benefits Section:

Brand-Name Medication means a Prescription Medication that is marketed and sold by limited sources or is listed in widely accepted references (or as specified by the Claims Administrator) as a Brand-Name Medication based on manufacturer and price.

Compound Medication means two or more medications that are mixed together by the Pharmacist. To be covered, Compound Medications must contain a at least one Prescription Medication and must not contain any ingredient or bulk chemical that is excluded or otherwise not covered by the Plan.

Covered Prescription Medication Expense means the total payment a Participating Pharmacy or Mail-Order Supplier has contractually agreed to accept as full payment for a Prescription Medication. A Participating Pharmacy or Mail-Order Supplier may not charge You more than the Covered Prescription Medication Expense for a Prescription Medication.

Formulary means the PBM's list of selected Prescription Medications. The PBM established and routinely reviews and updates the Formulary. It is available on the PBM's website at www.savrx.com or by calling Sav-Rx Customer Service at 1 (800) 228-3108. Medications are reviewed and selected for inclusion in the Formulary by an outside committee of Providers, including Physicians and Pharmacists.

Generic Medication means a Prescription Medication that is equivalent to a Brand-Name Medication and is listed in widely accepted references (or specified by the PBM) as a Generic Medication. For the purpose of this definition, exhaust administrative remedies "equivalent" means the FDA ensures that the Generic Medication has the same active ingredients, meets the same manufacturing and testing standards and is as safe and as effective as the Brand-Name Medication. If listings in widely accepted references are conflicting or indefinite about whether a Prescription Medication is a generic or Brand-Name Medication, the PBM will decide.

Mail-Order Supplier means a mail-order Pharmacy with which the PBM has contracted for mail-order services.

Pharmacist means an individual licensed to dispense Prescription Medications, counsel a patient about how the medication works and its possible adverse effects and perform other duties as described in exhaust administrative remedies state's Pharmacy practice act.

Pharmacy means any duly licensed outlet in which Prescription Medications are dispensed. A Participating Pharmacy means either a Pharmacy with which the PBM has a contract or a Pharmacy that participates in a network for which the PBM has contracted to have access. Participating Pharmacies have the capability of submitting claims electronically. A Nonparticipating Pharmacy means a Pharmacy with which the PBM neither has a contract nor has contracted access to any network it belongs to. Nonparticipating Pharmacies may not be able to or choose not to submit claims electronically.

Prescription Medications (also Prescribed Medications) means medications and biologicals that relate directly to the treatment of an Illness or Injury, legally cannot be dispensed without a Prescription Order and by law must bear the legend: "Prescription Only," or as specifically included on the PBM's Formulary.

Prescription Order means a written prescription or oral request for Prescription Medications issued by a Provider who is licensed to prescribe medications.

Self-Administrable Prescription Medications (also Self-Administrable Medications, or Self-Administrable Injectable Medication) means, a Prescription Medication, determined by the PBM, which can be safely administered by You or Your caregiver outside a medically supervised setting (such as a Hospital, Physician office or clinic) and that does not require administration by a Provider. In determining what are considered Self-Administrable Medications, the PBM refers to information from the manufacturer, scientific literature, practice standards, Medicare practices, Medical Necessity and other information that is considered a relevant and reliable indication of safety and acceptability. Your status, such as Your ability to administer the medication, will not be considered when determining whether a medication is self-administrable.

Specialty Medications means medications used by patients with complex disease states, such as but not limited to multiple sclerosis, rheumatoid arthritis, cancer and hepatitis C. For a list of some of these medications, please visit the PBM's website at www.savrx.com or by calling Sav-Rx Customer Service at 1 (800) 228-3108.

Specialty Pharmacy means a Pharmacy that specializes in the distribution and medication management services of high cost injectables and Specialty Medications. To find a Specialty Pharmacy, please visit the PBM's website at www.savrx.com or by calling the Sav-Rx Customer Service at 1 (800) 228-3108.

For more information contact the Claims Administrator at 1 (866) 240-9580 or You can write to P.O. Box 2998, Tacoma, WA 98401-2998

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