Idaho AGC HEALTH PLAN

Designed Exclusively for Idaho AGC members and their employees

Employee Benefit Plan

$5,000 Deductible PPO Basic & Deluxe

Effective Date: January 1, 2019

This coverage is not insurance and the Idaho AGC Self-Funded Benefit Trust does not participate in the State Guaranty Association

Prescription Drug Benefit:
Copay Option
Refer to SPD page 44

Summary Plan Description

This document and the related Benefits Booklet are intended to constitute the Plan's summary plan description for purposes of the Employee Retirement Income Security Act.
Policy is effective beginning January 1, 2019 and ending December 31, 2019
This plan provides coverage for more than one class of employees

Legal Name of the Plan:	Idaho AGC Benefit Trust and Idaho AGC Self-Funded Benefit Trust DBA: Idaho AGC Health Plan
Plan Number:	502 and 504
Name, Address and Telephone:	The Idaho Branch, Inc., The Associated General Contractors of America, Inc. 1649 W. Shoreline Drive, Suite 100 Boise, Idaho 83702 Phone: (208) 344-9755 A complete list of the employers and employee organizations sponsoring the Plan may be obtained upon written request to the Plan Administrator.
Employer Identification Number:	82-0096397
Type of Welfare Plan:	Life, Accidental Death & Dismemberment, Health Care and Short Term Disability Medical, Dental and Vision benefits are paid directly from the Idaho AGC Self-Funded Benefit Trust assets. Medical, Dental and Vision coverage is not insurance and the Idaho AGC Self-Funded Benefit Trust does not participate in State Guaranty Association.
Type of Plan Administration:	The Plan's billing, eligibility, COBRA and other non-benefit functions are administered by a contract administrator which is referred to as the Administrative Office. The Administrative Office is: The Idaho Branch, Inc., The Associated General Contractors of America, Inc. P.O. Box 7386 Boise, Idaho 83707 (208) 344-9755 Benefits of the plan are administered through insurance policies and health service contracts as follows: Health care benefits are provided through a service contract with: Blue Cross of Idaho Health Services, Inc. 3000 East Pine Avenue Meridian, Idaho 83642 Phone: (800) 365-2345 Dedicated Customer Service Line: Phone: (866) 283-6354 Phone: (208) 286-3439 (Treasure Valley)

Vision care benefits are provided through a service contract with:
Vision Service Plan (VSP)
3333 Quality Drive
Rancho Cordova, California 95670
Phone: (800) 877-7195

Dental benefits are provided through a service contract with:
Delta Dental of Idaho, Inc.
555 East Parkcenter Boulevard
Boise, Idaho 83706
Phone: (800) 388-3490

Employee assistance program benefits are provided through a service contract with:
BPA Health
380 E. Parkcenter Blvd., Suite 300
Boise, ID 83706
Phone: (800) 726-0003

Life, AD&D, and Short-Term disability benefits are provided through a service contract with:
The Lincoln National Life Insurance Company
8801 Indian Hills Drive
Omaha, Nebraska 68114-4066
Phone: (800) 423-2765

Plan's Fiscal Year End: December 31

Name, Address and Telephone Number of Administrator: The Plan Administrator is the Board of Trustees of the Idaho AGC Health Plan

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Buss Mechanical Services, Inc.
4473 Henry St.
Boise, ID 83709
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3000 Wright Rd
Idaho Falls, ID 83401
P: (208) 529-4925
adavis@eaglerocktimber.com

Name and address of agent for Service of Process:

The Administrative Office and each of the individual trustees are authorized to accept service of process on behalf of the Plan. This booklet includes a description of benefits available through the Idaho AGC Health Plan which includes:

Medical Benefits
Dental Benefits
Life and AD&D Insurance
Vision Benefits
Short-Term Disability Insurance
Employee Assistance Program Insurance

If you are unsure of your benefits, please contact your employer or The Idaho Branch, Inc., The Associated General Contractors of America, Inc., Idaho AGC Health Plan at (208) 344-9755 to verify coverage.

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Idaho AGC HEALTH PLAN

Your Rights as a Participant

The following notices outline the rights you may have as a participant of the Idaho AGC Health Plan. Please read this information carefully and contact the Idaho AGC Health Plan Office at (208) 344-9755 for assistance with your questions.

STATEMENT OF ERISA RIGHTS

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants are entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Administrative Office and other specified locations, such as work-sites andunion halls, all documents governing the Plan including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series), if required, filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.
- Obtain upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) if required, and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report, if any. The Plan Administrator is required by law to ffurnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

If the Federal group health plan continuation coverage law (called "COBRA") applies to your Employer, you have a right to continue health coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Reduction or Elimination of Preexisting Condition Waiting Periods

You have a right to a reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan benefits, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose group health plan coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage you may be subject to a pre-existing condition exclusion for 12 months after your enrollment date in your coverage.

Mother's and Newborn's Rights

Group health plans and health insurance issuers generally may not, under Federal law, 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 cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing the length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act Notice

Under Federal law, group health plans and health insurers that provide medical and surgical benefits in connection with a mastectomy must provide benefits for certain reconstructive surgery. In the case of a covered employee or dependent who is receiving medical benefits under the Plan in connection with a mastectomy and who elects breast reconstruction, Federal law requires coverage in a manner determined in consultation with the attending physician and the patient for:

- Reconstruction of the breast on which the mastectomy was performed, including implants;
- Surgical procedures and reconstruction of the non-affected breast to produce a symmetrical appearance, including implants; and

- Non-surgical treatment of lymphedemas and other physical complications of mastectomy, including non-surgical prostheses and implants for producing symmetry. This coverage is subject to the annual deductibles and coinsurance provisions described in the benefits section of your booklet. If you have any questions about whether your Plan covers mastectomies or reconstructive surgery, please contact the Plan administration office.

Notice of Special Enrollment Rights

If you decline enrollment in a group health plan benefit for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents for group health plan benefit coverage. However, you must request enrollment within 60 days' (or such longer period that applies under the group health plan benefit) after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact the Plan administration office.

Michelle's Law

Under the affordable Care Act, health plans cannot deny or restrict coverage for a child under the age of 26 based on student status.

Genetic Information Nondiscrimination Act of 2008

The Genetic Information Nondiscrimination Act of 2008 (GINA) protects employees against discrimination based on their genetic information. Unless otherwise permitted, your employer or health plan may not request or require any genetic information from you or your family members.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to act prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit under the Plan or from exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored in whole or in part you have the right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in Federal court. In such case, the court may require the Plan Administrator to provide the materials, and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If you do not follow the procedures and satisfy the deadlines for claims and the review of denied claims described in your Benefits Booklet, you will lose your right to file suit in State or Federal court, because you will not have exhausted your administrative remedies — which generally is a requirement for filing suit. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in Federal court. The court will decide who should pay court and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if the court finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Administrative Office. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Administrative Office, you should contact the nearest Office of the Employee Benefits Security Administration, U.S. Department of Labor listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

General Notice Of COBRA Continuation Coverage Rights

** Continuation Coverage Rights Under COBRA**

Introduction

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;

- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Idaho AGC Health Plan PO Box 7386 Boise, ID 83707 (208) 344-9755. Notices must be written and submitted on plan forms.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

The disability extension is available only if you notify the Trust Administrator in writing of the Social Security Administration's determination of disability within 60 days after the latest of:

- The date of the Social Security Administration's disability determination;
- The date of the covered employee's termination of employment or reduction of hours; and
- The date on which the qualified beneficiary loses (or would lose) coverage under the terms of the plan as a result on the covered employee's termination of employment or reduction of hours.

You must also provide this notice within 18 months after the covered employee's termination of employment or reduction of hours in order to be entitled to a disability extension. In providing this notice, you must use the plans form entitled "Notice of Disability Form" (you may obtain a copy of this form from the Trust Administrator at no charge or you can download the form a www.idahoagc.org/forms and you must follow the procedures specified at the end of this notice entitled "Notice Procedures". If these procedures are not followed or if the notice is not provide to the Trust Administrator during the 60-day notice period and within 18 months after the covered employee's termination of employment or reduction of hours, then there will be no disability extension of COBRA coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

This extension due to a second qualifying event is available only if you notify the Trust Administrator in writing of the second qualifying event within 60 days of the date of the second qualifying event.

In providing this notice, you must use the plans form entitled "Notice of Second Qualifying Event Form" (you may obtain a copy of this form from the Trust Administrator at no charge and you must follow the procedures specified in the box at the end of this notice entitled "Notice Procedures". If these procedures are not followed or if the notice is not provide to the Trust Administrator during the 60-day notice period, then there will be no extension of COBRA coverage due to a second qualifying event.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

More Information About Individuals Who May Be Qualified Beneficiaries

Children born to or placed for adoption with the covered employee during COBRA coverage period

A child born to, adopted by, or placed for adoption with a covered employee during a period of COBRA coverage is considered to be a qualified beneficiary provided that, if the covered employee is a qualified beneficiary, the covered employee has elected COBRA coverage for himself or herself. The child's COBRA coverage begins when the child is enrolled in the Plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the employee. To be enrolled in the Plan, the child must satisfy the otherwise-applicable Plan eligibility requirements (for example, regarding age).

Alternate recipients under QMCSOs

A child of the covered employee who is receiving benefits under the Plan pursuant to a qualified medical child support order (QMCSO) received by the Idaho AGC Health Plan during the covered employee's period of employment is entitled to the same rights to elect COBRA as an eligible dependent child of the covered employee.

Premium Payments

The premium you will be charged will not be more than 102% of the total cost of providing coverage. The premium for qualified beneficiaries with extended 11-month COBRA coverage due to a qualified beneficiary's SSA disability can be as much as 150% of the cost of coverage.

You will be notified of the cost of continuing benefits if you experience a qualifying event. You will have 45 days from the election date to pay the initial premium which includes the period of coverage from the date your coverage terminates (due to the Qualifying Event) to the date of your election; and any regularly scheduled monthly premium that becomes due between your election and the end of the 45-day period. **If you fail to make your first payment for COBRA coverage in full within 45 days after the date of your election, you will lose all COBRA rights under the Plan.**

Premium payments for subsequent months of COBRA coverage are due on the first day of each calendar month for that month's coverage. Premium payments received within 30 days of the due date (which is the first day of each month of coverage) will be considered timely payment. **If you fail to make a monthly payment before the end of the grace period for that month, you will lose all rights to COBRA coverage under the Plan.**

The Trust Administrator will not send periodic notices of payments due for these coverage periods. The Trust Administrator will not send a bill to you for your COBRA coverage – it is your responsibility to pay your COBRA premiums on time.

All COBRA premiums must be paid by check. Your first payment and all monthly payments for COBRA coverage must be mailed or hand-delivered to the individual at the payment address specified in the Election Notice provided to you at the time of the qualifying event. However, if the Plan notifies you of a new address for payment, you must mail or hand-deliver all payments for COBRA coverage to the individual at the address specified in that notice of a new address.

If mailed, your payment is considered to have been made on the date that it is postmarked. If hand-delivered, your payment is considered to have been made when it is received by the individual at the address specified above. You will not be considered to have made any payment by mailing of hand-delivering a check if your check is returned due to insufficient funds or otherwise.

Future Changes In Benefits And Premiums

If your employer changes any regular health plan benefits during your continuation period, your coverage will also be changed in the same manner. Your required monthly premiums may also change during your continuation period in the manner allowed by law*. You will be notified of any changes in benefits and/or rates during your continuation period.

*Note: Premiums may change only once in the determination year of the plan (once every 12 months).

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

Idaho AGC Health Plan
Trust Administrator
PO Box 7386
Boise, ID 83707
(208) 344-9755

This contact information for the Plan may change from time to time. The most recent information will be included in the Plan's most recent summary plan description (if you do not have a copy, you may request one from ABC Company).

Notice Procedures

Warning: If your notice is late or if you do not follow these notice procedures, you and all related qualified beneficiaries will lose the right to elect COBRA (or will lose the right to an extension of COBRA coverage, as applicable).

Notices Must Be Written and Submitted on Plan Forms:* Any notice that you provide must be in writing and must be submitted on the Plan's required form (the Plan's required forms are described above in this notice, and you may obtain copies from the Trust Administrator without charge or download them at *www.idahoagc.org/forms*. Oral notice, including notice by telephone, is not acceptable. Electronic (including e-mailed or faxed) notices are not acceptable.†

How, When, and Where to Send Notices: You must mail or hand deliver your notice to:

Trust Administrator
AGC Benefit Trust
Idaho AGC
P.O. Box 7386
Boise, ID 83707
(208) 344-9755

However, if a different address for notices to the Plan appears in the Plan's most recent summary plan description, you must mail or hand deliver your notice to that address (if you do not have a copy of the Plan's most recent summary plan description, you may request one from the Trust Administrator).

If mailed, your notice must be postmarked no later than the last day of the applicable notice period. If hand-delivered, your notice must be received by the individual at the address specified above no later than the last day of the applicable notice period. (The applicable notice periods are described in the paragraphs above entitled "You Must Give Notice of Some Qualifying Events," "Disability extension of COBRA coverage," and "Second qualifying event extension of COBRA coverage.")

Information Required for All Notices: Any notice you provide must include: (1) the name of the Plan (AGC Benefit Trust); (2) the name and address of the employee who is (or was) covered under the Plan; (3) the name(s) and address(es) of all qualified beneficiary(ies) who lost coverage as a result of the qualifying event; (4) the qualifying event and the date it happened; and (5) the certification, signature, name, address, and telephone number of the person providing the notice.

Additional Information Required for Notice of Qualifying Event: If the qualifying event is a divorce or legal separation, your notice must include a copy of the decree of divorce or legal separation. If your coverage is reduced or eliminated and later a divorce or legal separation occurs, and if you are notifying the AGC Benefit Trust that your Plan coverage was reduced or eliminated in anticipation of the divorce or legal separation, your notice must include evidence satisfactory to the AGC Benefit Trust that your coverage was reduced or eliminated in anticipation of the divorce or legal separation.

Additional Information Required for Notice of Disability: Any notice of disability that you provide must include: (1) the name and address of the disabled qualified beneficiary; (2) the date that the qualified beneficiary became disabled; (3) the names and addresses of all qualified beneficiaries who are still receiving COBRA coverage; (4) the date that the Social Security Administration made its determination; (5) a copy of the Social Security Administration's determination; and (6) a statement whether the Social Security Administration has subsequently determined that the disabled qualified beneficiary is no longer disabled.

Additional Information Required for Notice of Second Qualifying Event: Any notice of a second qualifying event that you provide must include: (1) the names and addresses of all qualified beneficiaries who are still receiving COBRA coverage; (2) the second qualifying event and the date that it happened; and (3) if the second qualifying event is a divorce or legal separation, a copy of the decree of divorce or legal separation.

Who May Provide Notices: The covered employee (i.e., the employee or former employee who is or was covered under the Plan), a qualified beneficiary who lost coverage due to the qualifying event described in the notice, or a representative acting on behalf of either may provide notices. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all qualified beneficiaries who lost coverage due to the qualifying event described in the notice.

IDAHO AGC HEALTH PLAN NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective date. The effective date of this Notice is January 1, 2012.

This Notice is required by law. The Idaho AGC Health Plan (the "Plan") is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

1. The Plan's uses and disclosures of Protected Health Information (PHI),
2. Your rights to privacy with respect to your PHI,
3. The Plan's duties with respect to your PHI,
4. Your right to file a complaint with the Plan and with the Secretary of the United States Department of Health and Human Services (HHS), and
5. The person or office you should contact for further information about the Plan's privacy practices.

This Notice is intended to summarize the Plan's obligations and your rights under the law with respect to your PHI. This Notice is not a term or condition of the Plan, and this Notice does not create any obligations or rights with respect to your PHI under the terms of the Plan.

Your Protected Health Information

What is Protected Health Information (PHI)?

The term "Protected Health Information" (PHI) includes all individually identifiable health information related to your past, present or future physical or mental health condition or to payment for health care. PHI includes information maintained by the Plan in oral, written, or electronic form.

When Can the Plan Disclose Your PHI Without Your Authorization?

Under the law, the Plan may disclose your PHI without your consent or authorization, or the opportunity to agree or object, in the following cases:

- ***At your request.*** If you request it, the Plan is required to give you access to certain PHI in order to allow you to inspect and/or copy it.
- ***As required by HHS.*** The Secretary of the United States Department of Health and Human Services may require the disclosure of your PHI to investigate or determine the Plan's compliance with the privacy regulations.
- ***For treatment, payment or health care operations.*** The Plan and its business associates will use PHI in order to carry out treatment, payment or health care operations.

Treatment is the provision, coordination, or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers.

Payment includes but is not limited to actions to make coverage determinations and payment (including billing, claims management, subrogation, plan reimbursement, reviews for medical necessity and appropriateness of care and utilization review and preauthorizations).

Health care operations includes but is not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other

insurance activities relating to creating or renewing insurance contracts. It also includes disease management, case management, conducting or arranging for medical review, legal services, and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities.

Disclosure to your group health plan's Plan Sponsor. The Plan will also disclose PHI to the Plan Sponsor of your group health plan for purposes related to treatment, payment, and health care operations, if the Plan Sponsor has adopted amendments to its Plan Documents to permit this use and disclosure as required by federal law. For example, the Plan may disclose information to the Plan Sponsor to allow it to decide an appeal or review of an eligibility question or a subrogation claim.

Disclosure to Business Associates. The Plan will also disclose PHI to its Business Associates for purposes related to treatment, payment, and health care operations. A Business Associate is an individual or entity the Plan has contracted with to perform various functions on the Plan's behalf or to provide certain types of services. Business Associates will receive, create, maintain, use and/or disclose your PHI, but only after they agree in writing with the Plan to implement appropriate safeguards regarding your PHI. For example, the Plan may disclose your PHI to a Business Associate to administer claims or to provide support services, such as claims processing, utilization management or subrogation, but only after the Business Associate enters into a Business Associate contract with the Plan.

When Does the Disclosure of Your PHI Require Your Written Authorization?

Except as otherwise indicated in this Notice, uses and disclosures will be made only with your written authorization subject to your right to revoke your authorization.

When Does the Use or Disclosure of My PHI Require that I Be Given an Opportunity to Agree or Disagree Before its Use or Release?

Disclosure of your PHI to family members, other relatives, your close personal friends, and any other person you choose is allowed under federal law if:

1. The information is directly relevant to the family or friend's involvement with your care or payment for that care, and

2. You have either agreed to the disclosure or have been given an opportunity to object and have not objected.

When Is the Use or Disclosure of My PHI Permitted and My Consent, Authorization or Opportunity to Object Is Not Required

The Plan is allowed under federal law to use and disclose your PHI without your consent or authorization under the following circumstances:

1. ***When required by applicable law.***
2. ***Public health purposes.*** To an authorized public health authority if required by law or for public health and safety purposes. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law.
3. ***Domestic violence or abuse situations.*** When authorized by law to report information about abuse, neglect or domestic violence to public authorities if a reasonable belief exists that you may be a victim of abuse, neglect or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm.
4. ***Health oversight activities.*** To a health oversight agency for oversight activities authorized by law. These activities include civil, administrative or criminal investigations, inspections, licensure or disciplinary actions (for example, to investigate complaints against health care providers) and other activities necessary for appropriate oversight of government benefit programs (for example, to the Department of Labor).
5. ***Legal proceedings.*** When required for judicial or administrative proceedings. For example, your PHI May be disclosed in response to a subpoena or discovery request that is accompanied by a court order.

6. ***Law enforcement health purposes.*** When required for law enforcement purposes (for example, to report certain types of wounds).
7. ***Law enforcement emergency purposes.*** For certain law enforcement purposes, including:
   a. identifying or locating a suspect, fugitive, material witness or missing person, and
   b. disclosing information about an individual who is or is suspected to be a victim of a crime.
8. ***Determining cause of death and organ donation.*** When required to be given to a coroner or medical examiner to identify a deceased person, determine a cause of death or other authorized duties. The Plan may also disclose PHI for organ, eye or tissue donation purposes.
9. ***Funeral purposes.*** When required to be given to funeral directors to carry out their duties with respect to the decedent.
10. ***Research.*** For research, subject to certain conditions.
11. ***Health or safety threats.*** When, consistent with applicable law and standards of ethical conduct, the Plan in good faith believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.
12. ***Workers' compensation programs.*** When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.
13. ***Military and Veterans.*** When required to be given to military command authorities and you are a member of the armed forces.
14. ***National Security and Intelligence Activities.*** When required to be given to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
15. ***Inmates.*** When required to be given to a correctional institution or law enforcement official for the health and safety of inmates or for the safety and security of the correctional institution.

Are there Other Uses or Disclosures?

The Plan may contact you to provide you information about treatment alternatives or other health-related benefits and services that may be of interest to you.

The Plan may disclose protected health information to your group health plan sponsor for reviewing your appeal of a benefit claim or for other reasons regarding the administration of the Plan or your employer's group health plan.

What is the Potential Impact of State Law?

In some situations, the Plan may choose to follow state privacy or other applicable laws that provide greater privacy protections to individuals. If a state law that we follow requires that we not use or disclose PHI, such as age of majority or parental notification restrictions, then we may not use or disclose that information.

Your Individual Privacy Rights

Can I Request Restrictions on Uses and Disclosures of my PHI?

You may request the Plan to:

1. Restrict the uses and disclosures of your PHI to carry out treatment, payment or health care operations, or

2. Restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care.

We will comply with any restriction request if: (1) except as otherwise required by law, the disclosure is to the Plan for purposes of carrying out payment or health care operations, and is not for purposes of carrying out treatment; and (2) the PHI pertains solely to a health care item or service for which the health care provider involved has been paid out-of-pocket in full.

Except as provided in the previous paragraph, the Plan, however, is not required to agree to your request if the Plan determines your request to be unreasonable.

To request restrictions, you must make your request in writing to: The Plan's Privacy Officer who is Susan Fudge. She can be contacted at the Idaho AGC Health Plan, Idaho AGC, P.O. Box 7386, Boise, ID 83707, (208) 344-9755 You must tell the Plan (1) what information you want to limit; (2) whether you want to limit the Plan's use, disclosure, or both; and (3) to whom you want the limits to apply, for example, to disclosures to your spouse.

Can I Request Confidential Communications?

The Plan will accommodate an individual's reasonable request to receive communications of PHI by alternative means or at alternative locations where the request includes a statement that disclosure could endanger the individual.

You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI. Make such requests to: The Privacy Officer, listed above.

Can I Inspect and Copy My PHI?

You have a right to inspect and obtain a copy of your PHI for as long as the Plan maintains the PHI.

The Plan must provide the requested information within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Plan is unable to comply with the deadline.

You or your personal representative will be required to complete a form to request access to the PHI. A reasonable fee may be charged. Requests for access to PHI should be made to the following officer: The Privacy Officer, listed above.

If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise your review rights and a description of how you may complain to the Plan and HHS.

Do I Have the Right to Amend My PHI?

You have the right to request that the Plan amend your PHI or a record about you for as long as the PHI is maintained subject to certain exceptions.

The Plan has 60 days after receiving your request to act on it. The Plan is allowed a single 30-day extension if the Plan is unable to comply with the 60-day deadline. If the Plan denied your request in whole or part, the Plan must provide you with a written denial that explains the basis for the decision. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of that PHI.

You should make your request to amend PHI to the following officer: The Privacy Officer, listed above.

You or your personal representative will be required to complete a written form to amendment of the PHI and include a reason to support the requested amendment.

Do I Have the Right to Receive an Accounting of the Plan's Disclosures of My PHI?

At your request, the Plan will also provide you with an accounting of certain disclosures by the Plan of your PHI. The Plan is not required to provide you with an accounting of disclosures related to treatment, payment, or health care operations, or disclosures made to you or authorized by you in writing.

The Plan has 60 days to provide the accounting. The Plan is allowed an additional 30 days if the Plan gives you a written statement of the reasons for the delay and the date by which the accounting will be provided.

If you request more than one accounting within a 12-month period, the Plan will charge a reasonable fee for each subsequent accounting.

Do I Have the Right to be Notified of a Breach?

You have the right to be notified in the event that the Plan (or a Business Associate) discovers a breach of unsecured protected health information.

Do I Have the Right to Receive a Paper Copy of This Notice Upon Request? Yes. To obtain

a paper copy of this Notice, contact the Privacy Officer, listed above. ***Can My Personal***

Representative Act on My Behalf Regarding My Privacy Rights?

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of authority to act on your behalf before the personal representative will be given access to your PHI or be allowed to take any action for you. Proof of such authority will be a completed, signed and approved Appointment of Personal Representative form. You may obtain this form by calling the Plan Administration Office.

The Plan retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect.

The Plan will recognize certain individuals as personal representatives without you having to complete an Appointment of Personal Representative form. For example, the Plan will automatically consider a spouse to be the personal representative of an individual covered by a group health plan. In addition, the Plan will consider a parent or guardian as the personal representative of an unemancipated minor unless applicable law requires otherwise. A spouse or a parent may act on an individual's behalf, including requesting access to their PHI. Spouses and unemancipated minors may, however, request that the Plan restrict information that goes to family members.

The Plan's Duties Regarding Privacy

Maintaining Your Privacy

The Plan is required by law to maintain the privacy of your PHI and to provide you and your eligible dependents with notice of its legal duties and privacy practices.

This Notice is effective beginning on January 1, 2012 and the Plan is required to comply with the terms of this Notice. However, the Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Plan prior to that date. If a privacy practice is changed, a revised version of this Notice will be provided to you and to all past and present participants and beneficiaries for whom the Plan still maintains PHI via mail.

Any revised version of this Notice will be distributed within 60 days of the effective date of any material change to:

- The uses or disclosures of PHI,
- Your individual rights,
- The duties of the Plan, or
- Other privacy practices stated in this notice.

This Notice is intended to summarize the Plan’s obligations and your rights under the law with respect to your PHI. This Notice is not a term or condition of the Plan, and this Notice does not create any obligations or rights with respect to your PHI under the terms of the Plan.

Disclosing Only the Minimum Necessary Protected Health Information

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

However, the minimum necessary standard will not apply in the following situations:

- Disclosures to or requests by a health care provider for treatment,
- Uses or disclosures made to you,
- Disclosures made to the Secretary of the United States Department of Health and Human Services pursuant to its enforcement activities under HIPAA,
- Uses or disclosures required by law, and
- Uses or disclosures required for the Plan's compliance with the HIPAA privacy regulations. This

Notice does not apply to information that has been de-identified. De-identified information is information that:

- Does not identify you, and
- With respect to which there is no reasonable basis to believe that the information can be used to identify you.

In addition, the Plan may use or disclose "summary health information" to your group health plan's Plan Sponsor for obtaining premium bids or modifying, amending or terminating the group health plan. Summary information summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a Plan Sponsor has provided health benefits under a group health plan. Identifying information will be deleted from summary health information, in accordance with HIPAA.

Your Right to File a Complaint with the Plan or the HHS Secretary

If you believe that your privacy rights have been violated, you may file a complaint with the Plan in care of the following individual:

Ginger Sinclair Health
Plan Director Idaho AGC
Health Plan Idaho AGC
P.O. Box 7386
Boise, ID 83707
(208) 344-9755

You may also file a complaint with:

Secretary of the U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue S.W.
Washington, D.C. 20201

The Plan will not retaliate against you for filing a complaint.

If You Need More Information

If you have any questions regarding this notice or the subjects addressed in it, you may contact the

Following individual at the Plan Administrative Office:

Ginger Sinclair
Sr. Health Plan Director
Idaho AGC Health Plan
P.O. Box 7386
Boise, ID 83707
(208) 344-9755

Conclusion

PHI use and disclosure by the Plan is regulated by the federal Health Insurance Portability and Accountability Act, known as HIPAA. You may find these rules at 45 *Code of Federal Regulations* Parts 160 and 164. This Notice attempts to summarize the regulations. The regulations will supersede this Notice if there is any discrepancy between the information in this Notice and the regulations.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT

USERRA (the Uniformed Services Employment and Reemployment Rights Act of 1994) provides employees who leave work to serve in the uniformed services of the United States with certain rights upon their return from service. USERRA also permits these employees to elect to continue coverage under their employer's group health plan for themselves and their dependents for a limited time.

Continuation of Health Plan Coverage under USERRA

If an employee or an employee's dependent will lose group health plan coverage because the employee will be absent from work to serve in the uniformed services, the employee can elect to continue coverage for the employee and the employee's dependents.

USERRA continuation coverage lasts for up to 24 months after the employee's absence begins. Coverage terminates before the 24-month period when any of the following events occur:

- a premium payment is not made within the required time;
- the employee fails to return to work (or apply for reemployment) with his or her participating employer within the time required under USERRA (see "Returning to Work" below) following the completion of service in the uniformed services;
- the employee loses his or her rights under USERRA as a result of a dishonorable discharge or other conduct specified in USERRA;
- the employee becomes covered under the Plan as an active employee of the participating employer. USERRA continuation coverage for a dependent also ends when coverage for a dependent who is not receiving USERRA coverage would end.

Returning to Work. The employee's right to continue coverage under USERRA ends if he or she does not report to work or apply for reemployment with the participating employer after completing service in the uniformed services as described below:

- **If the service is less than 31 days or the employee is absent for any period of time for purposes of an examination for fitness to perform service**, the employee must return to work by the beginning of the first regularly scheduled work period on the day following the completion of the employee's service, after allowing for safe travel home and an eight-hour rest period, or if that is unreasonable or impossible through no fault of the employee, as soon as is possible.
- **If the service is more than 30 days but less than 181 days**, the employee must apply for reemployment within 14 days after completion of service or, if that is unreasonable or impossible through no fault of the employee, the first day on which it is possible to do so.
- **If the service is more than 180 days**, the employee must apply for reemployment within 90 days after completion of service.
- **If the employee was hospitalized for or was convalescing from an injury or illness incurred or aggravated as a result of the employee's service**, the time to return to work or submit an application for reemployment is extended to the end of the period necessary for the employee to recover from the illness or injury. This period may not extend for more than two years after the employee's completion of service, except the two-year period may be extended if circumstances beyond the employee's control make it impossible or unreasonable for the employee to report to work within the above time periods.

The Plan can require a premium for USERRA continuation coverage.

Reinstatement in Group Health Plan Coverage upon Return from Uniformed Service

If group health plan coverage for the employee or the employee's dependents terminated due to the employee's service in the uniformed services of the United States (whether at the beginning of or during that service), and the employee is entitled to reinstatement with his or her participating employer under USERRA, the coverage must be reinstated when the employee becomes reemployed. (Under USERRA an employee has a right to reemployment only if certain requirements are satisfied, including timely return to work or application for reemployment as described in "Returning to Work" above.) No exclusion or waiting period may be imposed in connection with the reinstatement of coverage upon reemployment, if that exclusion or waiting period would not have been imposed had coverage not been terminated by reason of the employee's service

in the uniformed services. A health plan, however, may impose an exclusion or waiting period as to illnesses or injuries determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services.

USERRA and COBRA Continuation Coverage

If the Plan is subject to COBRA, both the USERRA continuation coverage and COBRA continuation coverage rules may apply when an employee is absent from work to perform service in the uniformed services. The employee's absence generally results in a COBRA qualifying event — a loss of coverage due to the employee's termination of employment or reduction in hours. The employee has the right to elect to continue coverage under both COBRA and USERRA. This means that the employee and other COBRA qualified beneficiaries are entitled to the greater protection under COBRA or USERRA. In the administration of USERRA, the Plan will follow the COBRA procedures for establishing the contribution rates, and the form and timing of notices.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2019. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: Medicaid www.medicaid.georgia.gov - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
IOWA – Medicaid	**KANSAS – Medicaid**
Website: http://dhs.iowa.gov/hawk-i Phone: 1-800-257-8563	Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512

KENTUCKY – Medicaid	NEW HAMPSHIRE – Medicaid
Website: https://chfs.ky.gov Phone: 1-800-635-2570	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll-Free: 1-800-852-3345, ext 5218
LOUISIANA – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	**NEW YORK – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MASSACHUSETTS – Medicaid and CHIP	**NORTH CAROLINA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MINNESOTA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739 or 651-431-2670	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MISSOURI – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MONTANA – Medicaid	**OREGON – Medicaid and CHIP**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
NEBRASKA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEVADA – Medicaid	**RHODE ISLAND – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347

SOUTH CAROLINA – Medicaid	VIRGINIA – Medicaid and CHIP
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://health.wyo.gov/healthcarefin/medicaid/ Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 31, 2019, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 12/31/2019)

Health Insurance Marketplace Coverage Options and Your Health Coverage

General Information

In 2014, the Affordable Care Act brought about a new way for you to buy your health insurance. This option is known as the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution –as well as your employee contribution to employer-offered coverage– is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact the Idaho AGC Health Plan at (208) 344-9755 or HealthPlanTeam@idahoagc.org..

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PLAN UPDATES
To Your
Group Plan

Please Read Carefully

This *Plan Update* is a summary of the changes to your health insurance coverage effective on January 1, 2019. We encourage you to review this carefully. For reference, the words and terms capitalized in this document are defined in your member contract.

Medical Deductibles

- The medical deductibles for four of the six Plans will change as outlined below:
  - $1,500 PPO deductible plan will increase to $1,750
  - $2,500 PPO deductible plan will increase to $2,750
  - $3,000 PPO deductible plan will increase to $3,250
  - $4,500 PPO deductible plan will increase to $5,000

  Note: the deductible for the $1,000 PPO plan and the $3,000 PPO HDHP plan will not change for 2019.

In Network and Out-of-Network Coinsurance

- The participant's portion of the coinsurance will change to 30% for in-network services and 50% for out-of-network services, for all applicable services on all Plans.

Out-Patient Emergency Facility Copayment

- The Participant's copayment for a hospital Outpatient emergency room visit is $350 for all plans.

In Network Out-of-Pocket Limit

- The Participant's In-Network Out-of-Pocket expenses incurred during the benefit period will change for all plans as outlined below:
  - $7,350 per individual / $14,700 per family for the $1,000, $1,750, $2,750, $3,250 and the $5,000 deductible plans.
  - $6,750 per individual / $13,500 per family for the $3,000 HDHP Plan

Out-of-Network Out-of-Pocket Limit

- The Participant's Out-of-Network Out-of-Pocket expenses incurred during the benefit period will change for all plans as outlined below:
  - $14,700 per individual / $29,400 per family for the $1,000, $1,750, $2,750, $3,250 and the $5,000 deductible plans.
  - $13,500 per individual / $27,000 per family for the $3,000 HDHP Plan

Specialty Office Copay

- The Specialty office copayment will change to $50.

Prescription Drug Option 2 Deductible

- Prescription Drug Option 2 annual deductible will change to $500.

Benefits Outline

- If you receive this document and/or any other notices electronically, you have the right to receive paper copies of the electronic documents upon request at no additional charge.

Major Medical Benefits

- Added a benefit for Outpatient Applied Behavioral Analysis (ABA) as part of an approved treatment plan.
- Removed all visit limits for Autism Spectrum Disorder services identified as part of the approved treatment plan.

- Updated the Transplant Language to include hematopoietic, CAR T-Cell, and other autotransplants as Medically Necessary.

Eligibility Section
- Updated the Eligible Dependent language to state the child of a Surrogate Mother is not considered an Eligible Dependent under the Plan.

Prescription Drug
- Updated the prior authorization response timeline for prescription drugs to fourteen (14) days following receipt of the medical information necessary to make the determination.

Definitions Section
- Added definitions for Applied Behavioral Analysis (ABA), Autism Spectrum Disorder, and Treatments for Autism Spectrum Disorder.
- Updated the term "Technology Evaluation Center (TEC)" to "Center for Clinical Effectiveness (CCE)".
- Updated the definition of Home Health Skilled Nursing Care Services, and removed the definition of Home Health Nursing.
- Modified the definition of Surrogate.

General Provisions Section
- Updated the Inquiry and Appeals Procedures section to clarify a Participant must complete an "Appointment of Authorized Representative" form to authorize another individual to act on the Participant's behalf.

Please note: Any changes made to your benefit plan by your employer are not included in this *Plan Update.* This *Plan Update* is only a brief highlight of the changes made by the Idaho AGC Health Plan.

IDAHO BRANCH, INC., ASSOCIATED GENERAL CONTRACTORS OF AMERICA, INC.

Idaho AGC Self-Funded Benefit Trust

Employee Benefits Plans
$5,000 Deductible PPO Basic & Deluxe

Effective January 1, 2019 – December 31, 2019

Administered by Blue Cross of Idaho

This coverage is not insurance and the Idaho AGC Self-Funded Benefit Trust does not participate in the State Guaranty Association

PREVENTIVE CARE

Blue Cross of Idaho

Form No. 3-1309NI (06-18)

Highlights of Your Preventive Care Benefits:

Preventive care is when you see a doctor or have a screening when you don't have any signs of a medical problem. It can help your doctor discover small problems before they get bigger.

Find a list of covered preventive care services below or at ***members.bcidaho.com***. Select the ***Health & Wellness*** tab, then ***Preventive Care Services***.

- You pay nothing; no coinsurance, copayment or deductible, for covered preventive care services when you visit in-network providers.
- Preventive care benefits for services from out-of-network providers are subject to your out-of-network benefit.

Covered Preventive Care Services	In-Network	Out-of-Network
Specifically Listed Services Annual adult physical examinations; Routine or scheduled well-baby and well-child examinations, including vision, hearing and developmental screenings; Dental fluoride application for participants age 5 and younger; Bone density; Chemistry panels; Cholesterol screening; Colorectal cancer screening (colonoscopy, sigmoidoscopy, fecal occult blood test); Complete Blood CouWatitis B virus screening; Sexually transmitted infections assessment; HIV assessment; Screening and assessment for interpersonal and domestic violence; Urinalysis (UA); Aortic aneurysm ultrasound; Alcohol misuse assessment; Breast cancer (BRCA) risk assessment and genetic counseling and testing for high-risk family history of breast or ovarian cancer; Newborn metabolic screening (PKU, Thyroxine, Sickle Cell); Health risk assessment for depression; Newborn hearing test; Lipid disorder screening; Smoking cessation counseling visit; Dietary counseling (limited to 3 visits per participant, per benefit period); Behavioral counseling for participants who are overweight or obese; Preventive lead screening; Lung cancer screening for participants age 55 and older; Hepatitis C virus infection screening; Gestational diabetes screening for pregnant women; Iron deficiency screening for pregnant women; Rh (D) incompatibility screening for pregnant women; and Urine culture for pregnant women.	You pay nothing of the allowed amount for specifically listed preventive care services per person, per benefit period. No copayment, deductible or coinsurance required.	You pay costs subject to your out-of-network benefit.
Women's Preventive Health Services *(Applies to group and individual plan members unless otherwise noted.)*	**In-Network**	**Out-of-Network**
Well Woman visits (for recommended age-appropriate preventive services); breastfeeding support, supplies and counseling.	You pay nothing of the allowed amount for specifically listed preventive care services per person, per benefit period. No copayment, deductible or coinsurance required.	You pay costs subject to your out-of-network benefit.
Blue Cross of Idaho pays 100 percent for women's preventive prescription drugs and devices as specifically listed on the Blue Cross of Idaho website, ***bcidaho.com***; deductible does not apply. The day supply allowed shall not exceed a 90-day supply at one (1) time, as applicable to the specific contraceptive drug or supply.		
Prescribed Contraceptive Services Includes diaphragms, intrauterine devices (IUDs), implantables, injections and tubal ligation		
Immunizations	**In-Network**	**Out-of-Network**
Accellular Pertussis, Diphtheria, Hemophilus Influenza B, Hepatitis B, Influenza, Measles, Mumps, Pneumococcal (pneumonia), Poliomyelitis (polio), Rotavirus, Rubella, Tetanus, Varicella (Chicken Pox), Hepatitis A, Meningococcal, Human Papillomavirus (HPV) and Zoster. All Immunizations are limited to the extent recommended by the Advisory Committee on Immunization Practices (ACIP) and may be adjusted accordingly to coincide with federal government changes, updates and revisions.	You pay nothing for specifically listed immunizations. No copayment, deductible or coinsurance required.	

Immunizations	In-Network	Out-of-Network
Other immunizations not specifically listed may be covered when Medically Necessary and approved by the Blue Cross of Idaho Pharmacy and Therapeutics Committee.	You pay costs subject to your in-network benefit.	You pay costs subject to your out-of-network benefit.

Please Note: Your provider must bill these services as preventive/wellness services.

The specifically listed preventive care services may be adjusted accordingly to coincide with federal government changes, updates, and revisions.

The descriptions above are general in nature, to allow for an overall view of Blue Cross of Idaho's preventive care coverage. For complete descriptions of your policy and policy changes, please read your contract and contract amendment language.

Well Child Immunization and Visit Schedule

Giving Your Kids a Healthy Start

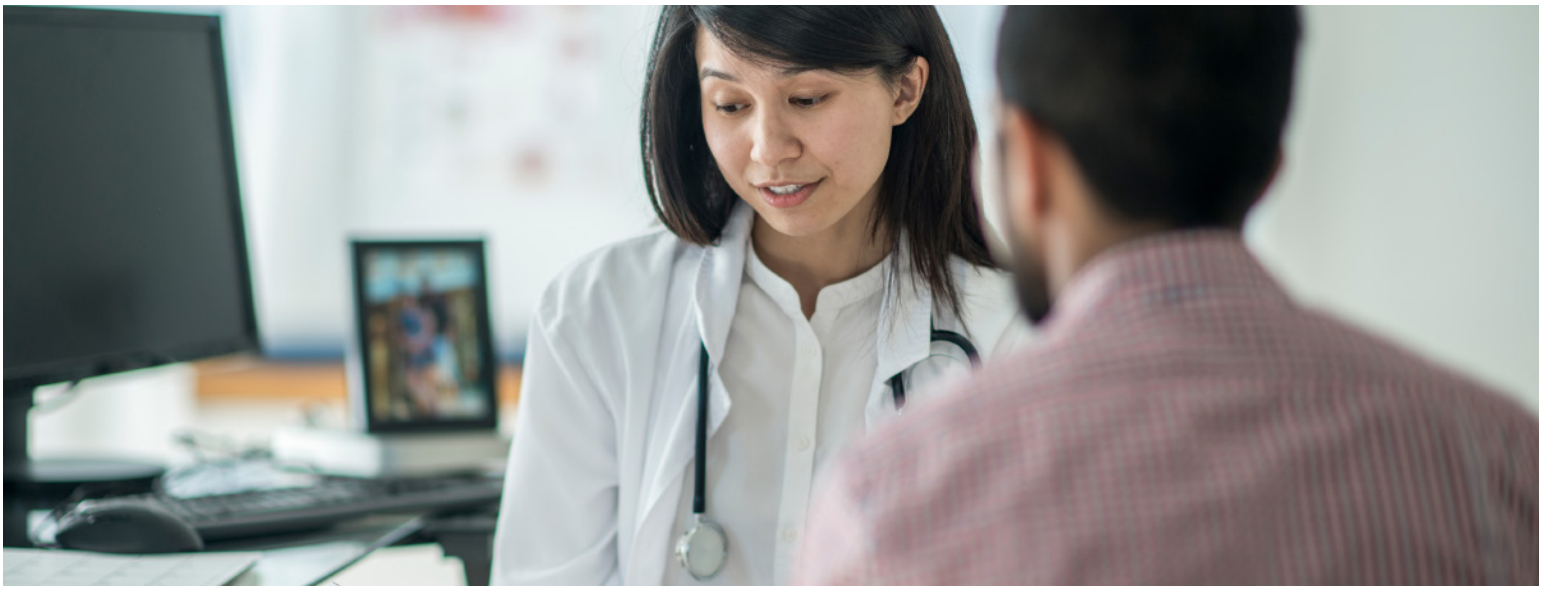
Getting your child vaccinated is one of the best steps you can take for a healthy start in life. Not too long ago, diseases like measles, whooping cough and polio affected thousands of children, sometimes leading to lifelong disability or even death. Now, vaccines can help prevent children from ever suffering from these diseases.

Vaccines are administered during Well Child visits with your child's healthcare provider. These visits include a complete physical exam, developmental milestones, immunization schedules and more.

The American Academy of Pediatrics Bright Futures suggest the following schedule for Well Child visits unless otherwise suggested by your pediatrician.

Age	Activity	Immunization/ Test
2 weeks	Exam, Health Education	None
2 months	Exam, Health Education	DTaP-Polio-Hib, Hepatitis B, Pneumococcal, Rotavirus
4 months	Exam, Health Education	DTaP-Polio-Hib, Hepatitis B (if birth dose not given), Pneumococcal, Rotavirus
6 months	Exam, Health Education	DTaP-Polio-Hib, Pneumococcal, Hepatitis B, Rotavirus
9 months	Exam, Health Education	None
12 months	Exam, Health Education	MMR, VZV, Hepatitis A, Anemia test, Lead test, TB test as needed
15 months	Exam, Health Education	DTaP-Polio-Hib, Pneumococcal
18 months	Exam, Health Education	Hepatitis A
24 months	Exam, Health Education	Lead test, TB test as needed
30 months	Exam, Health Education	None
3 years	Exam, Health Education	Blood Pressure (at each exam 3 yrs & older)
4 years	Exam, Health Education	MMR, VZV, DTaP, Polio
5 years	Exam, School Readiness	Vision and Hearing Screens (MMR, VZV, DTaP, Polio if not given at 4 year WCC)
6-10 years	Exam, Health Education Physical Exam Yearly	Catch-up Immunizations
11-18 years	Annual Sports/Adolescent Exam Yearly	Tdap, Meningococcal, HPV Catch-up Immunizations Anemia Test (menstruating females)

Your Pediatrician will review immunizations on each visit for the needs of your child.
www.completechildrenshealth.com/education-resources/immunization-schedule.php



Preventive Schedule

Make a Plan for Your Health

People plan ahead for many things – vacations, buying tickets to the big game or making reservations at busy restaurants – because they want to make sure they have access to things that are important.

Planning ahead in healthcare is a good idea, too. There are certain services that you need annually, including wellness visits and flu shots, which you can schedule months in advance. By doing so, you can be sure you aren't scrambling to find an appointment later in the year.

Scheduling early also has other benefits, like being able to chose the time of your visit. Whether you prefer morning, afternoon or weekend appointments, scheduling early gives you the best chance at getting the dates and times you prefer.

✔ CHECK WHEN COMPLETED	FREQUENCY	DATE SCHEDULED
❒ Annual Wellness Exam	Every 12 months	
❒ Blood Pressure	At least annually*	
❒ Cholesterol	Every 5 years*	
❒ Body Mass Index	Annually	
❒ Bone Mass Measurement	Every 1-2 years	
❒ Breast Cancer	Annually	
❒ Colon Cancer	Ask my doctor	
❒ Diabetes Screening (A1C)	At least annually*	
❒ Flu Vaccine	Annually	
❒ Immunizations	As needed*	
❒ Pneumonia Vaccine	Once after age 65	
❒ Well Baby/Well Child Exam	As recommended in Well Child Schedule	
❒ Well Woman Exam	Annually	

**Your primary care provider (PCP) will help determine frequency.*

Depending on your health and personal risk factors, your preventive care schedule may differ from the standard recommendations. Talk with your doctor about a schedule that's best for you. If you have particular risk factors like a chronic disease, obesity, or a family history of a disease, your PCP may recommend additional screenings.

ASC PREFERRED BLUE MASTER GROUP PLAN BENEFITS OUTLINE

WOMEN'S HEALTH AND CANCER RIGHTS ACT NOTICE:
The Women's Health and Cancer Rights Act of 1998 requires health plans to provide the following mastectomy-related services.

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

OBSTETRIC OR GYNECOLOGICAL CARE NOTICE:
You do not need prior authorization from Blue Cross of Idaho or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, please visit our Web site at www.bcidaho.com. You may also call our Customer Service Department at (208)-286-3439 or (866)-283-6354 for assistance in locating a Provider.

EMERGENCY SERVICES
For the treatment of Emergency Medical Conditions or Accidental Injuries of sufficient severity to necessitate immediate medical care by, or that require Ambulance Transportation Service to, the nearest appropriate Facility Provider, BCI, on behalf of the Trust, will provide In-Network benefits for Covered Services provided by either a Contracting or Noncontracting Facility Provider and facility-based Professional Providers only. If the nearest Facility Provider is Noncontracting, once the Participant is stabilized and is no longer receiving emergency care the Participant (at BCI's option, on behalf of the Trust,) may transfer to the nearest appropriate Contracting Facility Provider for further care in order to continue to receive In-Network benefits for Covered Services. If the Participant is required to transfer, transportation to the Contracting Facility Provider will be a Covered Service under the Ambulance Transportation Service provision of this Plan.

This Benefits Outline describes the benefits of this Plan in general terms. It is important to read the Plan in full for specific and detailed information that includes additional exclusions and limitations on benefits. Your manager of employee benefits should be able to help if you have questions.

If Participants receive these documents and/or any other Plan notices electronically, Participants have the right to receive paper copies of the electronic documents, including summary plan descriptions and plan amendments, upon request at no additional charge.

Throughout this Plan, Blue Cross of Idaho may be referred to as BCI. For Covered Services under the terms of this Plan, Maximum Allowance is the amount established as the highest level of compensation for a Covered Service. There is more detailed information on how Maximum Allowance is determined and how it affects out-of-state coverage in the Definitions Section.

To locate a Contracting Provider in your area, please visit the BCI Web site at www.bcidaho.com. You may also call our Customer Service Department at (208)-286-3439 or (866)-283-6354 for assistance in locating a Provider.

NONDISCRIMINATION STATEMENT: DISCRIMINATION IS AGAINST THE LAW
Blue Cross of Idaho complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Blue Cross of Idaho does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Blue Cross of Idaho:

- 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, 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, contact Blue Cross of Idaho's Customer Service Department. Call 1- 866-283-6354 (TTY: 1-800-377-1363), or call the customer service phone number on the back of your card.

If you believe that Blue Cross of Idaho 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 Blue Cross of Idaho's Grievances and Appeals Department at:

Manager, Grievances and Appeals
3000 East Pine Avenue, Meridian, Idaho 83642
Telephone: (800) 274-4018 ext.3838, Fax: (208) 331-7493
Email: grievances&appeals@bcidaho.com
TTY: 1-800-377-1363

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Grievances and Appeals team is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TTY).

Complaint forms are available at ***http://www.hhs.gov/ocr/office/file/index.html. Reference: https://federalregister.gov/a/2016-11458***

Language Assistance

ATTENTION: If you speak Arabic, Chinese, French, German, Korean, Japanese, Persian (Farsi), Romanian, Russian, Serbo-Croatian, Spanish, Sudanic Fulfulde, Tagalog, Ukrainian, or Vietnamese, language assistance services, free of charge, are available to you. Call 1- 866-283-6354 (TTY: 1-800-377-1363).

Arabic
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1- 866-283-6354 (رقم هاتف الصم والبكم:1-800-377-1363).

Chinese 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- 866-283-6354 (TTY：1-800-377-1363)。

French ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1- 866-283-6354 (ATS : 1-800-377-1363).

German ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1- 866-283-6354 (TTY: 1-800-377-1363).

Japanese 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- 866-283-6354 (TTY: 1-800-377-1363）まで、お電話にてご連絡ください。

Korean 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1- 866-283-6354 (TTY: 1-800-377-1363)번으로 전화해 주십시오.

Persian-Farsi

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت اریگان برای شما
فرا مه می باشد. با (TTY: 1-800-377-1363) 1- 866-283-6354 تماس بگیرید.

Romanian ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1- 866-283-6354 (TTY: 1-800-377-1363).

Russian ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1- 866-283-6354 (телетайп: 1-800-377-1363).

Serbo-Croation OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1- 866-283-6354 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1-800-377-1363).

Spanish ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1- 866-283-6354 (TTY: 1-800-377-1363).

Sudanic Fulfulde MAANDO: To a waawi [Adamawa], e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1- 866-283-6354 (TTY: 1-800-377-1363).

Tagalog PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1- 866-283-6354 (TTY: 1-800-377-1363).

Ukrainian УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1- 866-283-6354 (телетайп: 1-800-377-1363).

Vietnamese CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1- 866-283-6354 (TTY: 1-800-377-1363).

ELIGIBILITY AND ENROLLMENT

You are eligible for coverage under this Plan if you are in a classification of employees designated as eligible for coverage by your employer and you satisfy a probationary period established by your employer and you satisfy one of the following hour requirements:

1. If you became enrolled in the plan prior to June 1, 1996, your customary employment excluding overtime must be at least 80 hours per month to have continuing coverage under the plan.
2. If you became enrolled after May 31, 1996, your customary employment excluding overtime must be at least 120 hours per month to have continuing coverage under the plan.
3. If you work on State or Federally funded projects subject to the Davis-Bacon Act or the State equivalent Act, your employer may cover you as an Hour Bank employee. As an Hour Bank employee, you must complete 140 hours of service with your employer and receive credit for 140 hours in your Hour Bank under the plan to be eligible for coverage under the Plan.

(see the Plan for additional Eligibility and Enrollment provisions)

PROBATIONARY PERIOD

After you satisfy the probationary period established by your employer, your coverage under the Plan will commence on the first of the month following the month in which you satisfy the hour requirements described above.

Note: In order to receive maximum benefits, some Covered Services require Emergency Admission Notification, Non-Emergency Preadmission Notification, and/or Prior Authorization. Please review the Inpatient Admission Notification Section and/or the Prior Authorization Section of your Plan and Attachment A to this Benefits Outline for specific details.

Participants should check with BCI to determine if the treatment or service being considered requires Prior Authorization. All Inpatient Admissions and Emergency Admissions require Inpatient Notification Review or Emergency Admission Review, as appropriate.

If a Participant chooses a Noncontracting or a nonparticipating Provider, the Participant may be responsible for any charges that exceed the Maximum Allowance.

COMPREHENSIVE MAJOR MEDICAL BENEFITS		
Deductibles: **Individual** **Family** *(No Participant may contribute more than the Individual Deductible amount toward the Family Deductible)*	Participant pays the first $**5,000** In-Network and Out-of-Network Services for eligible expenses per Benefit Period. Participants pay the first $**10,000** In-Network and Out-of-Network Services for eligible expenses for all Participants under same Family Coverage per Benefit Period.	
	In-Network	**Out-of-Network**
Out-of-Pocket Limits: (See Plan for services that do not apply to the limit) *(Includes applicable Deductible, Cost-sharing and Copayments)* **Individual** **Family** *(No Participant may contribute more than the Individual Out-of-Pocket Limit amount toward the Family Out-of-Pocket Limit)*	Participant pays first $7,350 of In-Network eligible expenses per Benefit Period Participants pay a combination of $14,700 of In-Network eligible expenses for all Participants under same Family Coverage per Benefit Period *When the Out-of-Pocket Limit is met, benefits payable for Covered Services increases to 100% of the Maximum Allowance during the remainder of the Benefit Period, except for services that do not apply to the limit as listed in the Plan.*	Participant pays first $14,700 of Out-of-Network eligible expenses per Benefit Period Participants pay a combination of $29,400 of Out-of-Network eligible expenses for all Participants under same Family Coverage per Benefit Period *When the Out-of-Pocket Limit is met, benefits payable for Covered Services increases to 100% of the Maximum Allowance during the remainder of the Benefit Period, except for services that do not apply to the limit as listed in the Plan.*
Be aware that your actual costs for services provided by an Out-of-Network Provider may exceed this Plan's Out-of-Pocket Limit for Out-of-Network services. Your costs for the following Covered Services do not accumulate toward the Out-of-Network Out-of-Pocket Limit if delivered by an Out-of-Network Provider: Dental Services, Vision Services and Prescription Drug Services. In addition, Out-of-Network Providers can bill you for the difference between the amount charged by the Provider and the amount allowed by Blue Cross of Idaho, and that amount is not counted toward the Out-of-Network Out-of-Pocket Limit.		

SERVICES THE PLAN COVERS	AMOUNT OF PAYMENT	
Allergy Injections	**In-Network**	**Out-of-Network**
	Participant pays $5 Copayment per visit if this is the only service provided during the visit	Plan pays 50% of Maximum Allowance after Deductible
Ambulance Transportation Services	**In-Network**	**Out-of-Network**
	Plan pays 70% of Maximum Allowance after Deductible	Plan pays 50% of Maximum Allowance after Deductible
Breastfeeding Support and Supply Services *(Includes rental and/or purchase of manual or electric breast pumps. Limited to one (1) breast pump purchase per Benefit Period, per Participant. Hospital Grade Breast Pumps require Prior Authorization)*	**In-Network**	**Out-of-Network**
	Plan pays 100% of Maximum Allowance (Deductible does not apply)	Plan pays 50% of Maximum Allowance after Deductible
Chiropractic Care Services	**In-Network**	**Out-of-Network**
	Plan pays 70% of Maximum Allowance after Deductible	Plan pays 50% of Maximum Allowance after Deductible
	(Up to a combined total of 20 visits per Participant, per Benefit Period)	
Dental Services Related to Accidental Injury	**In-Network**	**Out-of-Network**
	Plan pays 70% of Maximum Allowance after Deductible	Plan pays 50% of Maximum Allowance after Deductible
Diabetes Self-Management Education Services *(Only for accredited Providers approved by BCI)*	**In-Network**	**Out-of-Network**
	Participant pays $30 Copayment per visit *(Deductible does not apply)*	Plan pays 50% of Maximum Allowance after Deductible
	(Up to a combined annual benefit limit of 4 visits per Participant, per Benefit Period)	
Diagnostic Services *(Includes diagnostic mammograms)*	**In-Network**	**Out-of-Network**
	Plan pays 70% of Maximum Allowance after Deductible	Plan pays 50% of Maximum Allowance after Deductible
Durable Medical Equipment/ Orthotic Devices / Prosthetic Appliances	**In-Network**	**Out-of-Network**
	Plan pays 70% of Maximum Allowance after Deductible	Plan pays 50% of Maximum Allowance after Deductible

	In-Network	Out-of-Network
Emergency Services – Facility Services *(Copayment waived if admitted)*	Requires $350 Copayment per hospital Outpatient emergency room visit Plan pays 70% of Maximum Allowance after Deductible	Requires $350 Copayment per hospital Outpatient emergency room visit Plan pays 50% of Maximum Allowance after Deductible *(For treatment of Emergency Medical Conditions as defined in the Plan, the Plan will provide In-Network benefits for Covered Services. Participant may be balance-billed for these services.)*
	In-Network	**Out-of-Network**
Emergency Services – Professional Services	Plan pays 70% of Maximum Allowance after Deductible	Plan pays 50% of Maximum Allowance after Deductible *(For treatment of Emergency Medical Conditions as defined in the Plan, the Plan will provide In-Network benefits for Covered Services. Participant may be balance-billed for these services.)*
	In-Network	**Out-of-Network**
Growth Hormone Therapy	Plan pays 70% of Maximum Allowance after Deductible	Plan pays 50% of Maximum Allowance after Deductible
	In-Network	**Out-of-Network**
Home Health Skilled Nursing Care Services	Plan pays 70% of Maximum Allowance after Deductible	Plan pays 50% of Maximum Allowance after Deductible
	In-Network	**Out-of-Network**
Home Intravenous Therapy	Plan pays 70% of Maximum Allowance after Deductible	Plan pays 20% of Maximum Allowance after Deductible
	In-Network	**Out-of-Network**
Hospice Services	Plan pays 100% of Maximum Allowance (Deductible does not apply)	Plan pays 50% of Maximum Allowance after Deductible
	In-Network	**Out-of-Network**
Hospital Services	Plan pays 70% of Maximum Allowance after Deductible	Plan pays 50% of Maximum Allowance after Deductible

Maternity Services and/or Involuntary Complications of Pregnancy	**In-Network** Plan pays 70% of Maximum Allowance after Deductible	**Out-of-Network** Plan pays 50% of Maximum Allowance after Deductible
Outpatient Habilitation Therapy Services • Outpatient Occupational Therapy • Outpatient Physical Therapy • Outpatient Speech Therapy	**In-Network** Plan pays 70% of Maximum Allowance after Deductible (Up to combined total of 20 visits per Participant, per Benefit Period)	**Out-of-Network** Plan pays 50% of Maximum Allowance after Deductible
Outpatient Rehabilitation Therapy Services • Outpatient Occupational Therapy • Outpatient Physical Therapy • Outpatient Speech Therapy	**In-Network** Plan pays 70% of Maximum Allowance after Deductible (Up to combined total of 20 visits per Participant, per Benefit Period)	**Out-of-Network** Plan pays 50% of Maximum Allowance after Deductible
Outpatient Cardiac Rehabilitation Therapy Services	**In-Network** Plan pays 70% of Maximum Allowance after Deductible	**Out-of-Network** Plan pays 50% of Maximum Allowance after Deductible
Outpatient Respiratory Therapy Services	**In-Network** Plan pays 70% of Maximum Allowance after Deductible	**Out-of-Network** Plan pays 50% of Maximum Allowance after Deductible
Physician Office Visits *Additional services, such as laboratory, x-ray, and other Diagnostic Services are not included in the Office Visit*	**In-Network** Participant pays $30 Copayment per visit for Primary Care Provider Participant pays $50 Copayment per visit for Specialist Provider (non-Primary Care Provider)	**Out-of-Network** Plan pays 50% of Maximum Allowance after Deductible
Post-Mastectomy/Lumpectomy Reconstructive Surgery	**In-Network** Plan pays 70% of Maximum Allowance after Deductible	**Out-of-Network** Plan pays 50% of Maximum Allowance after Deductible
Prescribed Contraceptive Services *(Includes diaphragms, intrauterine devices (IUDs), implantables, injections and tubal ligation.)*	**In-Network** Plan pays 100% of Maximum Allowance (Deductible does not apply)	**Out-of-Network** Plan pays 50% of Maximum Allowance after Deductible
Psychiatric Inpatient Services • Inpatient Facility and Professional Services	**In-Network** Plan pays 70% of Maximum Allowance after Deductible	**Out-of-Network** Plan pays 50% of Maximum Allowance after Deductible

Psychiatric Outpatient Services • Outpatient Psychotherapy Services • Facility and other Professional Services	**In-Network** Participant pays $30 Copayment per visit Plan pays 70% of Maximum Allowance after Deductible	**Out-of-Network** Plan pays 50% of Maximum Allowance after Deductible
Outpatient Applied Behavioral Analysis (ABA) *(as part of an approved treatment plan)*	**In-Network** Participant pays $30 Copayment per visit	**Out-of-Network** Plan pays 50% of Maximum Allowance after Deductible
Treatment for Autism Spectrum Disorder *(Services identified as part of the approved treatment plan)*	**In-Network** Covered the same as any other illness, depending on the services rendered. Please see the appropriate section of the Benefit Outline. Visit limits do not apply to Treatments for Autism Spectrum Disorder.	**Out-of-Network** Covered the same as any other illness, depending on the services rendered. Please see the appropriate section of the Benefit Outline. Visit limits do not apply to Treatments for Autism Spectrum Disorder.
Rehabilitation or Habilitation Services	**In-Network** Plan pays 70% of Maximum Allowance after Deductible	**Out-of-Network** Plan pays 50% of Maximum Allowance after Deductible
Skilled Nursing Facility	**In-Network** Plan pays 70% of Maximum Allowance after Deductible	**Out-of-Network** Plan pays 50% of Maximum Allowance after Deductible
	(Up to a combined total of 30 days per Participant, per Benefit Period)	
Surgical/Medical (Professional Services)	**In-Network** Plan pays 70% of Maximum Allowance after Deductible	**Out-of-Network** Plan pays 50% of Maximum Allowance after Deductible
Temporomandibular Joint (TMJ) Syndrome Services	**In-Network** Plan pays 70% of Maximum Allowance after Deductible	**Out-of-Network** Plan pays 50% of Maximum Allowance after Deductible
	(Up to a combined Lifetime Benefit Limit of $2,000 per Participant)	
Therapy Services *(Including Radiation, Chemotherapy and Renal Dialysis)*	**In-Network** Plan pays 70% of Maximum Allowance after Deductible	**Out-of-Network** Plan pays 50% of Maximum Allowance after Deductible
Transplant Services	**In-Network** Plan pays 70% of Maximum Allowance after Deductible	**Out-of-Network** Plan pays 50% of Maximum Allowance after Deductible

PREVENTIVE CARE BENEFITS		
	In-Network	**Out-of-Network**
For specifically listed Covered Services *Annual adult physical examinations; routine or scheduled well-baby and well-child examinations, including vision, hearing and developmental screenings; Dental fluoride application for Participants age 5 and under; Bone Density; Chemistry Panels; Cholesterol Screening; Colorectal Cancer Screening; Complete Blood Count (CBC); Diabetes Screening; Pap Test; PSA Test; Rubella Screening; Screening EKG; Screening Mammogram; Thyroid Stimulating Hormone (TSH); Transmittable Diseases Screening (Chlamydia, Gonorrhea, Human Immunodeficiency Virus (HIV), Human papillomavirus (HPV), Syphilis, Tuberculosis (TB)); Hepatitis B Virus Screening; Sexually Transmitted Infections assessment; HIV assessment; Screening and assessment for interpersonal and domestic violence; Urinalysis (UA); Aortic Aneurysm Ultrasound; Alcohol Misuse Assessment; Breast Cancer (BRCA) Risk Assessment and Genetic Counseling and Testing for High Risk Family History of Breast or Ovarian Cancer; Newborn Metabolic Screening (PKU, Thyroxine, Sickle Cell); Health Risk Assessment for Depression; Newborn Hearing Test; Lipid Disorder Screening; Smoking Cessation Counseling Visit; Dietary Counseling (limited to 3 visits per Participant, per Benefit Period); Behavioral Counseling for Participants who are overweight or obese; Preventive Lead Screening; Lung Cancer Screening for Participants age 55 and over; Hepatitis C Virus Infection Screening; Urinary Incontinence Screening; For Participating Employee or the Enrolled Eligible Dependent spouse: Urine Culture for Pregnant Women; Iron Deficiency Screening for Pregnant Women; Rh (D) Incompatibility Screening for Pregnant Women; Diabetes Screening for Pregnant Women.* *The specifically listed Preventive Care Services may be adjusted accordingly to coincide with federal government changes, updates, and revisions.*	Plan pays 100% of Maximum Allowance (Deductible does not apply)	Plan pays 50% of Maximum Allowance after Deductible
For services not specifically listed	Plan pays 70% of Maximum Allowance after Deductible	Plan pays 50% of Maximum Allowance after Deductible

	In-Network	Out-of-Network
Immunizations *Accellular Pertussis, Diphtheria, Hemophilus Influenza B, Hepatitis B, Influenza, Measles, Mumps, Pneumococcal (pneumonia), Poliomyelitis (polio), Rotavirus, Rubella, Tetanus, Varicella (Chicken Pox,), Hepatitis A, Meningococcal, Human papillomavirus (HPV) and Zoster.* *All Immunizations are limited to the extent* ***recommended*** *by the Advisory Committee on Immunization Practices (ACIP) and may be adjusted accordingly to coincide with federal government changes, updates and revisions.*	Listed immunizations require no Copayment, Deductible, or Cost-sharing	Listed immunizations require no Deductible or Cost-sharing
Other immunizations not specifically listed may be covered at the discretion of BCI when Medically Necessary.	Plan pays 70% of Maximum Allowance after Deductible	Plan pays 50% of Maximum Allowance after Deductible

Note: Please refer to Cover Sheet for Prescription Drug Benefit Option selected by Employer.

PRESCRIPTION DRUG BENEFITS – COPAY OPTION *Each non Specialty Prescription Drug shall not exceed a 90-day supply at one (1) time* *Prescription Drug Services apply to the In-Network Out-of-Pocket Limits*	
RETAIL PHARMACIES: 90 day supply with multiple Copayments *(one Copayment for each 30-day supply)* **MAIL ORDER:** 90 day supply with two Copayments	
Tier 1 Preferred Generic Prescription Drugs	Participant pays $7 Copayment per prescription
Tier 2 Non-Preferred Generic Prescription Drugs	Participant pays $7 Copayment per prescription
Tier 3 Preferred Brand Name Prescription Drugs	Participant pays 30% Cost-sharing per prescription
Tier 4 Non-Preferred Brand Name Prescription Drugs	Participant pays 50% Cost-sharing per prescription
Tier 5 Preferred Specialty Prescription Drugs and Generic Specialty Prescription Drugs *(30 day supply limit at one time)*	Participant pays 30% Cost-sharing per prescription
Tier 6 Non-Preferred Specialty Prescription Drugs *(30 day supply limit at one time)*	Participant pays 50% Cost-sharing per prescription
ACA Preventive Prescription Drugs	Plan pays 100% for Preventive Prescription Drugs as specifically listed on the BCI Formulary on the BCI Web site, www.bcidaho.com. (Deductible does not apply)
Prescribed Contraceptives	Plan pays 100% for Women's Preventive Prescription Drugs and devices as specifically listed on the BCI Formulary on the BCI Web site, www.bcidaho.com; Deductible does not apply. The day supply allowed shall not exceed a 90-day supply at one (1) time, as applicable to the specific contraceptive drug or supply. The Plan allows the right to request an exception for any FDA-approved contraceptive not included on BCI's formularies or one that is included with cost-sharing. Under the exceptions process, if a Participant's attending Provider recommends a particular FDA-approved contraceptive based on a determination of Medical Necessity with respect to that Participant, the Plan will cover that service or item without cost sharing. Contact Customer Service to obtain the appropriate request form.
Note: Certain prescription drugs have generic equivalents. If the Participant requests a Brand Name Drug, the Participant is responsible for the difference between the price of the Generic Drug and the Brand Name Drug, regardless of the Preferred or Non-Preferred status.	

Attachment A:
NON-EMERGENCY SERVICES REQUIRING PRIOR AUTHORIZATION ANNUAL NOTICE

NOTICE: ***Prior Authorization is required to determine if specified services are Medically Necessary and a Covered Service.***

Prior Authorization is not a guarantee of payment. It is a pre-service determination of Medical Necessity based on information provided to Blue Cross of Idaho at the time the Prior Authorization request is made. Blue Cross of Idaho retains the right to review the Medical Necessity of services, eligibility of services and benefit limitations and exclusions after services are received. If Prior Authorization has not been obtained to determine Medical Necessity, services may be subject to denial. Any dispute involved in Blue Cross of Idaho's Medical Necessity decision must be resolved by use of the Blue Cross of Idaho appeal process as outlined in the General Provisions Section.

Blue Cross of Idaho will respond to a request for Prior Authorization for the services listed below received from either the Provider or the Participant within seventy-two (72) hours for an expedited request or fourteen (14) days for a standard request of the receipt of the medical information necessary to make a determination. For additional information, please check with your Provider, call Customer Service at the telephone number listed on the back of the Participant's Identification Card or check the BCI Web site at www.bcidaho.com.

For the complete list of services that require Prior Authorization under the categories below, refer to the BCI Web site, www.bcidaho.com.

- Non-emergent Inpatient admissions
- Specified surgical services
- Advanced imaging services (not applicable for Emergency room or Inpatient services):
- Other Outpatient or home based services
- Certain Prescription Drugs and Outpatient infusion therapy
- Non-emergent Ambulance transport
- Specialty lab services
- Certain mental health and substance abuse services
- Durable Medical Equipment, Prosthetics and Orthotics over a select dollar threshold

ASC PREFERRED BLUE

MASTER GROUP PLAN

AND

PARTICIPATING EMPLOYEE CERTIFICATE

GROUP PLAN
FOR

Idaho AGC Self-Funded Benefit Trust

Effective Date: January 1, 2019

Administered by Blue Cross of Idaho

This coverage is not insurance and the Idaho AGC Self-Funded Benefit Trust does not participate in the State Guaranty Association.

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BLUE CROSS OF IDAHO CONTACT INFORMATION

For general information, please contact your local Blue Cross of Idaho office:

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

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

Lewiston
(208) 746-0531

Mailing Address
P.O. Box 7408
Boise, ID 83707

Coeur d'Alene
1450 Northwest Blvd., Suite 106
Coeur d'Alene, ID 83814
(208) 666-1495

Pocatello
275 South 5th Ave., Suite 150
Pocatello, ID 83201
(208) 232-6206

Idaho Falls
1910 Channing Way
Idaho Falls, ID 83404
(208) 522-8813

Twin Falls
1503 Blue Lakes Blvd. N.
Twin Falls, ID 83301
(208) 733-7258

IDAHO DEPARTMENT OF INSURANCE CONTACT INFORMATION

Idaho Department of Insurance
Consumer Affairs
700 W State Street, 3rd Floor
PO Box 83720
Boise ID 83720-0043
1-800-721-3272 or www.DOI.Idaho.gov

HOW TO SUBMIT CLAIMS

A Participant must submit a claim to Blue Cross of Idaho (BCI) in order to receive benefits for Covered Services. There are two ways for a Participant to submit a claim:

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

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

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

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

2. Obtain a Member Claim Form from the Provider or any of BCI's offices, and follow the instructions. Use a separate billing and Member Claim form for each patient.

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

   Blue Cross of Idaho Claims Control
   Blue Cross of Idaho
   P.O. Box 7408
   Boise, ID 83707

For assistance with claims or health benefit information, please call BCI Customer Service at 1-866-283-6354 or (208) 286-3439.

How Blue Cross Of Idaho Notifies The Participant
BCI will send the Participant an Explanation of Benefits (EOB) either electronically or by mail, as soon as the claim is processed. The EOB will show all the payments BCI made and to whom the payments were sent. It will also explain any charges BCI did not pay in full. Participants should print the electronic copy and keep this EOB for their records. If a Participant would like a paper copy of their EOB, they may request one from BCI Customer Service.

INPATIENT NOTIFICATION SECTION

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

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

I. Non-Emergency Preadmission Notification

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

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

II. Emergency Admission Notification

When an Emergency Admission occurs for Emergency Medical Conditions and notification cannot be completed prior to admission due to the Participant's condition, the Participant, or his or her representative, should notify BCI within twenty-four (24) hours of the admission. If the admission is on a weekend or legal holiday, BCI should be notified by the end of the next working day after the admission.

This notification alerts BCI to the emergency stay.

III. Continued Stay Review

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

IV. Discharge Planning

BCI will provide information about benefits for various post-discharge courses of treatment.

PRIOR AUTHORIZATION SECTION

NOTICE: ***Prior Authorization is required to determine if the services listed in the Attachment A are Medically Necessary and a Covered Service.***

Prior Authorization is not a guarantee of payment. It is a pre-service determination of Medical Necessity based on information provided to Blue Cross of Idaho at the time the Prior Authorization request is made. Blue Cross of Idaho retains the right to review the Medical Necessity of services, eligibility of services and benefit limitations and exclusions after services are received. If Prior Authorization has not been obtained to determine Medical Necessity, services may be subject to denial. Any dispute involved in Blue Cross of Idaho's Medical Necessity decision must be resolved by use of the Blue Cross of Idaho appeal process as outlined in the General Provisions Section.

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

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

Noncontracting Providers: The Participant is responsible for obtaining Prior Authorization when seeking treatment from a Noncontracting Provider. The Participant is financially responsible for services performed by a Noncontracting Provider when those services are determined to be not Medically Necessary. The Participant is responsible for notifying BCI if the proposed treatment will be provided by a Noncontracting Provider.

COMPREHENSIVE MAJOR MEDICAL BENEFITS SECTION

This section specifies the benefits a Participant is entitled to receive for the Covered Services described, subject to the other provisions of this Plan.

I. Benefit Period

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

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

II. Deductible

A. Individual

The Individual Deductible is shown in the Benefits Outline.

B. Family

The Family Deductible is shown in the Benefits Outline.

III. Out-Of-Pocket Limit

The Out-of-Pocket Limit is shown in the Benefits Outline. Eligible Out-of-Pocket expenses include only the Participant's Deductible, Copayments and Cost-sharing, if applicable, for eligible Covered Services. If a Participant is admitted as an Inpatient at the end of a Benefit Period and the hospitalization continues uninterrupted into the succeeding Benefit Period, all eligible Out-of-Pocket expenses incurred for Inpatient Hospital Services are considered part of the Benefit Period in which the date of admission occurred.

A. Out-of-Pocket expenses associated with the following are not included in the In-Network Out-of-Pocket Limit:

1. Amounts that exceed the Maximum Allowance.
2. Amounts that exceed benefit limits.
3. Services covered under a separate Plan, if any.
4. Noncovered services or supplies.

B. Out-of-Pocket expenses associated with the following are not included in the Out-of-Network Out-of-Pocket Limit:

1. Amounts that exceed the Maximum Allowance.
2. Amounts that exceed benefit limits.
3. Dental care Covered Services.
4. Services covered under a separate Plan, if any.
5. Noncovered services or supplies.
6. Vision care Covered Services.
7. Prescription Drug Covered Services

IV. Providers

All Providers and Facilities must be licensed and/or registered by the state where the services are rendered, unless exempt by federal law, and must be performing within the scope of license in order for BCI to provide benefits.

V. Covered Services

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

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

The Benefits Outline, attached to this Plan, is an easy reference document that contains general payment information and a descriptive list of Covered Services. Benefits for Covered Services may be subject to Copayments, Deductibles, Cost-sharing, visit limits, and other limits specified in the Benefits Outline. Only the following are eligible Major Medical expenses:

A. Applied Behavioral Analysis (ABA) - Outpatient

Benefits are provided for ABA services subject to the following:

1. Services must be identified as part of an approved treatment plan.
2. Continuation of benefits is contingent upon approval by BCI of a plan of treatment.

B. Hospital Services

1. Inpatient Hospital Services

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

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

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

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

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

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

b) **Ancillary Services**

Licensed General Hospital services and supplies including:

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

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

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

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

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

(6) Oxygen and administration of oxygen.

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

(8) Diagnostic Services and Therapy Services.

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

2. **Outpatient Hospital Services**

a) **Emergency Care**

Licensed General Hospital services and supplies for the treatment of Accidental Injuries and Emergency Medical Conditions.

b) **Surgery**

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

c) **Therapy Services**

3. **Special Services**

a) **Preadmission Testing**

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

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

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

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

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

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

C. Skilled Nursing Facility

Benefits provided to an Inpatient of a Licensed General Hospital are also provided for services and supplies customarily rendered to an Inpatient of a Skilled Nursing Facility. If the Participant is receiving care at a Skilled Nursing Facility at the end of a Benefit Period, benefits shall not renew the following Benefit Period until the Participant is discharged. However, no benefits are provided when the care received consists primarily of:

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

D. Ambulance Transportation Service

Ambulance Transportation Service is covered for Medically Necessary transportation of a Participant within the local community by Ambulance under the following conditions:

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

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

For purposes of this section, Ambulance means a specially designed and equipped vehicle used only for transporting the sick and injured.

E. Psychiatric Care Services

1. Covered Psychiatric Care services include Intensive Outpatient Program (IOP), Partial Hospitalization Program (PHP), Residential Treatment Program, psychological testing/neuropsychological evaluation testing and Electroconvulsive Therapy (ECT).

Payments for Inpatient or Outpatient Psychiatric Services apply to Covered Services furnished by any of the following:

- Licensed General Hospital
- Alcoholism or Substance Abuse Treatment
- Psychiatric Hospital
- Licensed Clinical Social Worker (LCSW)
- Licensed Clinical Professional Counselor (LCPC)
- Licensed Marriage and Family Therapist (LMFT)
- Clinical Psychologist
- Physician
- Residential Treatment Facility

2. **Inpatient Psychiatric Care**
   The benefits provided for Inpatient hospital services and Inpatient medical services in this section are also provided for the care of Mental or Nervous Conditions, Alcoholism, Substance Abuse or Addiction, or any combination of these.
3. **Outpatient Psychiatric Care**
   The benefits provided for Outpatient Hospital Services and Outpatient Medical Services in this section are also provided for Mental or Nervous Conditions, Alcoholism, Substance Abuse or Addiction, or any combination of these. The use of Hypnosis to treat a Participant's Mental or Nervous Condition is a Covered Service.
4. **Outpatient Psychotherapy Services –** Covered Services include professional office visit services, family, individual and/or group therapy.

F. Maternity Services

The benefits provided for Licensed General Hospital Services and Surgical/Medical Services are also provided for the maternity services listed below when rendered by a Licensed General Hospital or Physician to the Participating Employee or the Participating Employee's spouse (if a Participant). Nursery care of a newborn infant is not a maternity service. Diagnostic x-ray and laboratory services related to pregnancy, childbirth or, miscarriage are covered.

No benefits are provided for any Normal Pregnancy or Involuntary Complications of Pregnancy for enrolled Eligible Dependent children (if a Participant). However, tests to determine pregnancy are covered. All other diagnostic x-ray and laboratory services related to pregnancy, childbirth, or miscarriage are not covered.

1. **Normal Pregnancy**
   Normal Pregnancy includes all conditions arising from pregnancy or delivery, including any condition usually associated with the management of a difficult pregnancy that is not defined below as an Involuntary Complication of Pregnancy.
2. **Involuntary Complications Of Pregnancy**
   a) Involuntary Complications of Pregnancy include, but are not limited to:
      (1) Cesarean section delivery, ectopic pregnancy that is terminated, spontaneous termination of pregnancy that occurs during a period of gestation in which a viable birth is not possible (miscarriage), puerperal infection, and eclampsia.
      (2) Conditions requiring Inpatient confinement (when the pregnancy is not terminated), the diagnoses of which are distinct from pregnancy but are adversely affected or are caused by pregnancy. These conditions include acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, but do not include false labor, occasional spotting, Physician-prescribed bed rest during pregnancy, morning sickness, hyperemesis gravidarum, preeclampsia, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy.
3. If you have a birth, benefits for any hospital length of stay in connection with childbirth for the mother or newborn child will include forty-eight (48) hours following a vaginal delivery and ninety-six (96) hours following a cesarean section delivery. Federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than forty-eight (48) hours or ninety-six (96) hours as applicable. For

stays in excess of forty-eight (48) hours or ninety-six (96) hours, additional benefits may be available under the terms of Item III., Continued Stay Review, in the Inpatient Notification Section.

G. Transplant Services

1. **Autotransplants**

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

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

2. **Transplants**

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

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

b) Benefits for Transplant(s) are subject to the following conditions:

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

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

d) A travel allowance may be available when the Participant is traveling to and from a Blue Distinction Centers for Transplants (BDCT) for Transplant Services that have received Prior Authorization by BCI. The Participant will be notified of their eligibility for this allowance upon Prior Authorization of the scheduled Transplant services.

3. **Exclusions And Limitations**

In addition to any other exclusions and limitations of this Plan, the following exclusions and limitations apply to Transplant or Autotransplant services. No benefits are available under this Plan for the following:

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

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

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

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

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

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

g) Any complication to the donor arising from a donor's Transplant Surgery is not a covered benefit under the Participant Transplant recipient's Plan or policy. If the donor is a BCI Participant, eligible to receive benefits for Covered Services, benefits for medical complications to the donor arising from Transplant Surgery will be allowed under the donor's policy.

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

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

H. Surgical/Medical Services

1. **Surgical Services**

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

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

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

d) **Surgical Assistant**—Medically Necessary services rendered by a Physician or other appropriately qualified surgical assistant who actively assists the operating surgeon in the performance of covered Surgery where an assistant is required. The percentage of the Maximum Allowance that is used as the actual Maximum Allowance to calculate the amount of payment under this section for Covered Services rendered by a surgical assistant is 20% for a Physician assistant and 10% for other appropriately qualified surgical assistants.

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

f) **Second And Third Surgical Opinion**

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

(2) Specifications:

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

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

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

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

2. **Inpatient Medical Services**

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

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

3. **Outpatient Medical Services**

The following Outpatient medical services rendered by a Physician or other Professional Provider to a Participant who is an Outpatient, provided such services are not related to pregnancy, Chiropractic Care, Mental or Nervous Conditions, Alcoholism, Substance Abuse or Addiction, except as specified elsewhere in this section:

a) **Emergency Care**—medical care for the treatment of an Accidental Injury or Emergency Medical Condition.

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

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

d) **Preventive Care Services**

Benefits are provided for:

(1) Preventive Care Covered Services—See Benefits Outline for complete list. Dietary Counseling, also referred to as "medical nutritional counseling", includes the assessment of a Participant's overall nutritional status followed by the assignment of individualized diet, counseling, and/or specialized nutrition therapies to treat a chronic illness or condition. Dietary Counseling is only covered under the Preventive Care Benefit and includes Dietary Counseling for

Diabetes. Dietary Counseling is covered only if provided by a doctor of medicine (M.D.), doctor of osteopathy (D.O.), Registered Dietitian, Physician Assistant (P.A.), or a Nurse Practitioner (N.P.).

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

e) **Physician Office Visit**—Physician office medical visits and consultations. Additional services, such as treatment and diagnosis of Mental/Nervous Conditions, or laboratory, x-ray, and other Diagnostic Services are not included in the Office Visit. Benefits for these services may be available under other areas in this Comprehensive Major Medical Section.

f) **Allergy Injections**

I. **Diagnostic Services**

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

J. **Therapy Services**

1. **Radiation Therapy**
2. **Chemotherapy**
3. **Renal Dialysis**
   a) The Maximum Allowance for Renal Dialysis is 125% of the current Medicare allowed amount for In-Network and Out-of-Network Providers, unless a different rate is negotiated with the treating Provider.
4. **Physical Therapy**
   a) Payment is limited to Physical Therapy Services related to Habilitative and Rehabilitative care, with reasonable expectation that the services will produce measurable improvement in the Participant's condition in a reasonable period of time. Physical Therapy Services are covered when performed by:
      (1) A Physician.
      (2) A Licensed Physical Therapist provided the Covered Services are directly related to a written treatment regimen prepared by the Therapist.
      (3) A Podiatrist.
   b) No benefits are provided for:
      (1) The following Physical Therapy Services when the specialized skills of a Licensed Physical Therapist are not required:
         (a) Range of motion and passive exercises that are not related to restoration of a specific loss of function but are useful in maintaining range of motion in paralyzed extremities.
         (b) Assistance in walking, such as that provided in support for feeble or unstable patients.
      (2) Facility-related charges for Outpatient Physical Therapy Services, health club dues or charges, or Physical Therapy Services provided in a health club, fitness facility, or similar setting.
      (3) General exercise programs, even when recommended by a Physician or a Chiropractic Physician, and even when provided by a Licensed Physical Therapist.
      (4) Maintenance, palliative or supportive care.
      (5) Behavioral modification services.
5. **Respiratory Therapy**
6. **Occupational Therapy**
   a) Payment is limited to Occupational Therapy Services related to Habilitative and Rehabilitative care, with reasonable expectation that the services will produce measurable improvement in the Participant's condition in a reasonable period of time. Occupational Therapy Services are covered when performed by:
      (1) A Physician.
      (2) A Licensed Occupational Therapist, provided the Covered Services are directly related to a written treatment regimen prepared by a Licensed Occupational Therapist and approved by a Physician.

b) No benefits are provided for:
   (1) Facility-related charges for Outpatient Occupational Therapy Services, health club dues or charges, or Occupational Therapy Services provided in a health club, fitness facility, or similar setting.
   (2) General exercise programs, even when recommended by a Physician or a Chiropractic Physician, and even when provided by a Licensed Occupational Therapist.
   (3) Maintenance, palliative or supportive care.
   (4) Behavioral modification services.

7. **Speech Therapy**

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

a) A Physician.
b) A Speech Therapist, provided the services are directly related to a written treatment regimen designed by the Therapist
c) No benefits are provided for:
   (1) Maintenance or supportive care.
   (2) Behavioral modification services.

8. **Growth Hormone Therapy**
9. **Home Intravenous Therapy (Home Infusion Therapy)**

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

K. Home Health Skilled Nursing Care Services

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

L. Hospice Services

1. **Conditions**

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

a) The attending or primary Physician must certify that the Participant is a terminally ill patient with a life expectancy of six (6) months or less.
b) The Participant must live within the Hospice's local geographical area.
c) The Participant must be formally accepted by the Hospice.
d) The Participant must have a designated volunteer Primary Care Giver at all times.
e) Services and supplies must be prescribed by the attending Physician and included in a Hospice Plan of Treatment approved in advance by BCI. The Hospice must notify BCI within one (1) working day of any change in the Participant's condition or Plan of Treatment that may affect the Participant's eligibility for Hospice Benefits.
f) Palliative care (which controls pain and relieves symptoms but does not provide a cure) must be appropriate to the Participant's Illness.

2. **Exclusions And Limitations**

No benefits are provided for:

a) Hospice Services not included in a Hospice Plan of Treatment and not provided or arranged and billed through a Hospice.
b) Continuous Skilled Nursing Care except as specifically provided as a part of Respite Care or Continuous Crisis Care.
c) Hospice benefits provided during any period of time in which a Participant is receiving Home Health Skilled Nursing Care benefits.

M. Chiropractic Care Services

a) Benefits are limited to Chiropractic Care Services related to a significant medical condition necessitating appropriate Medically Necessary evaluation and Neuromusculoskeletal Treatment services. Chiropractic Care Services are covered when:
   (1) Services are directly related to a written treatment regimen prepared and performed by a Chiropractic Physician.
   (2) Services must be related to recovery or improvement in function, with reasonable expectation that the services will produce measurable improvement in the Participant's condition in a reasonable period of time.

b) No benefits are provided for:
   (1) Surgery as defined in this Plan to include injections.
   (2) Laboratory and pathology services.
   (3) Range of motion and passive exercises that are not related to restoration of a specific loss of function.
   (4) Massage therapy, if not performed in conjunction with other modalities or manipulations.
   (5) Maintenance, palliative or supportive care.
   (6) Preventive or wellness care.
   (7) Facility-related charges for Chiropractic Care Services, health club dues or charges, or Chiropractic Care Services provided in a health club, fitness facility, or similar setting.
   (8) General exercise programs.
   (9) Diagnostic Services, except for x-rays to assist in the diagnosis and Neuromusculoskeletal Treatment plan as defined in this Plan.

N. Durable Medical Equipment

The lesser of the Maximum Allowance or billed charge for rental, (but not to exceed the lesser of the Maximum Allowance or billed charge for the total purchase price) or, at the option of BCI, on behalf of the Trust, the purchase of Medically Necessary Durable Medical Equipment required for therapeutic use. The Durable Medical Equipment must be prescribed by an attending Physician or other Professional Provider within the scope of license. No benefits are available for the replacement of any item of Durable Medical Equipment that has been used by a Participant for less than five (5) years (whether or not the item being replaced was covered under this Plan). Benefits shall not exceed the cost of the standard, most economical Durable Medical Equipment that is consistent, according to generally accepted medical treatment practices, with the Participant's condition. If the Participant and his or her Provider have chosen a more expensive treatment than is determined to be the standard and most economical by BCI, the excess charge is solely the responsibility of the Participant. Equipment items considered to be common household items are not covered.

Due to ongoing service requirements and safety issues relating to oxygen equipment, BCI will not limit the cost of oxygen and the rental of oxygen delivery systems to the purchase price of the system(s).

O. Prosthetic Appliances

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

Benefits for Prosthetic Appliances are subject to the following limitations:

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

7. No benefits are available for the replacement of any item of Prosthetic Appliances that has been used by a Participant for less than five (5) years (whether or not the item being replaced was covered under this Plan), with the exception of a Prosthetic Appliance used by an Eligible Dependent child who has outgrown the item.

P. Orthotic Devices

Orthotic Devices include but are not limited to, Medically Necessary braces, back or special surgical corsets, splints for extremities, and trusses, when prescribed by a Physician, Chiropractic Physician, Podiatrist, Licensed Physical Therapist or Licensed Occupational Therapist. Arch supports, other foot support devices, orthopedic shoes, and garter belts are not considered Orthotic Devices. Benefits shall not exceed the cost of the standard, most economical Orthotic device that is consistent, according to generally accepted medical treatment practices, with the Participant's condition. No benefits are available for the replacement of any item of Orthotic Devices that has been used by a Participant for less than five (5) years (whether or not the item being replaced was covered under this Plan), with the exception of an Orthotic Device used by an Eligible Dependent child who has outgrown the item.

Q. Dental Services Related To Accidental Injury

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

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

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

R. Rehabilitation or Habilitation Services

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

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

S. Diabetes Self-Management Education Services

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

T. Post-Mastectomy/Lumpectomy Reconstructive Surgery

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

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

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

U. Prescribed Contraceptive Services

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

There are no benefits for:

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

V. Temporomandibular Joint (TMJ) Syndrome Benefits are provided as specified in the Benefits Outline for services only if related to temporomandibular joint syndrome, including Surgery and supplies related to orthognathics or to the misalignment or discomfort of the temporomandibular joint, including splinting services and supplies.

W. Breastfeeding Support and Supply Services

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

X. Outpatient Cardiac Rehabilitation Therapy

Cardiac Rehabilitation is a Covered Service for Participants who have a clear medical need and who are referred by their attending Physician and (1) have a documented diagnosis of acute myocardial infarction (MI) within the preceding 12 months; (2) have had coronary artery bypass graft (CABG) Surgery; (3) have percutaneous transluminal coronary angioplasty (PTCA) or coronary stenting; (4) have had heart valve Surgery; (5) have had heart or heart-lung transplantation; (6) have current stable angina pectoris; or (7) have compensated heart failure.

Y. Sleep Study Services

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

Z. Approved Clinical Trial Services

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

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

AA. Treatment for Autism Spectrum Disorder

Payment is limited to Treatment for Autism Spectrum Disorder as identified in a treatment plan. Continuation of benefits is contingent upon approval by BCI of a plan of treatment.

VI. Additional Amount of Payment Provisions

Any amounts remaining unpaid for Covered Services under any other benefit section of this Plan (except the Supplemental Accident Benefit Section and Dental Benefit sections if applicable), are not eligible for payment under this Comprehensive Major Medical Benefits section. For Covered Services eligible for benefits under more than one benefit section of this Plan, the amount paid for Covered Services may be applied to any benefit limit(s) in each benefit section. Except as specified elsewhere in this Plan, BCI, on behalf of the Trust, will provide the following benefits for Covered Services after a Participant has satisfied his or her individual Deductible or, if applicable, the family Deductible has been satisfied:

A. For In-Network Services: Unless stated otherwise, for Major Medical Covered Services furnished in the state of Idaho, BCI will pay or otherwise satisfy a percentage of the Maximum Allowance (shown in the Benefits Outline) if the Covered Services were rendered by a Provider. Several Providers are paid at different rates

and/or have different benefit limitations as described in that specific benefit section and in the Benefits Outline.

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

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

1. If the Provider has a PPO agreement for claims payment with the Blue Cross and/or Blue Shield plan in the area where the Covered Services were rendered, BCI will base the payment on the local plan's Preferred Provider Organization payment arrangement and allow In-Network benefits. The Provider shall not make an additional charge to a Participant for amounts in excess of BCI's payment except for Deductibles, Cost-sharing, Copayments, and noncovered services.

2. If the Provider does not have a PPO agreement for claims payment with the Blue Cross and/or Blue Shield plan in the area where the Covered Services are rendered, BCI will base payment on the Maximum Allowance and allow Out-of-Network benefits. The Provider is not obligated to accept BCI's payment as payment in full. Neither BCI nor the Trust are responsible for the difference, if any, between BCI's payment and the actual charge.

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

D. A Noncontracting Provider inside or outside the state of Idaho is not obligated to accept BCI's payment as payment in full. Neither BCI nor the Trust are responsible for the difference, if any, between BCI's payment and the actual charge, unless otherwise specified. Participants are responsible for any such difference, including Deductibles, Cost-sharing, Copayments, charges for noncovered services and the amount charged by the Noncontracting Provider that is in excess of the Maximum Allowance.

E. Emergency Services

For the treatment of Emergency Medical Conditions or Accidental Injuries of sufficient severity to necessitate immediate medical care by, or that require Ambulance Transportation Service to, the nearest appropriate Facility Provider, BCI, on behalf of the Trust, will provide In-Network benefits for Covered Services provided by either a Contracting or Noncontracting Facility Provider and facility-based Professional Providers only. If the nearest Facility Provider is Noncontracting, once the Participant is stabilized and is no longer receiving emergency care, the Participant (at BCI's option, on behalf of the Trust,) may transfer to the nearest appropriate Contracting Facility Provider for further care in order to continue to receive In-Network benefits for Covered Services. If the Participant is required to transfer, transportation to the Contracting Facility Provider will be a Covered Service under the Ambulance Transportation Service provision of this Plan.

PRESCRIPTION DRUG BENEFITS SECTION

Note: Please refer to Cover Sheet for Prescription Drug Benefit Option selected by Employer.

This Prescription Drug Benefits Section specifies the benefits a Participant is entitled to receive for Covered Services described in this section, subject to all of the other provisions of this Plan.

I. Prescription Drug Copayment/Cost-sharing/Deductible/Out-of-Pocket

For the types and levels of benefits coverage regarding Prescription Drugs, see the Benefits Outline.

Diabetic Supplies:

Insulin syringes/needles have no Copayment/Cost-sharing if purchased within ninety (90) days of insulin purchase. All other supplies will be subject to applicable Cost-sharing, Copayment and/or Deductible.

II. Providers

The following are Providers under this section:
Licensed Pharmacist
Participating Pharmacy/Pharmacist
Physician

III. Dispensing Limitations

Retail:
Each covered prescription for a Prescription Drug is limited to no more than a ninety (90)-day supply. Specialty Drugs are limited to no more than a thirty (30)-day supply. However, certain prescriptions and Prescription Drugs may be subject to more restrictive day-supply and allowed quantity limitations.

Mail Order:
Each covered prescription for a Prescription Drug is limited to no more than a ninety (90)-day supply. Specialty Drugs are limited to no more than a thirty (30)-day supply. However, certain prescriptions and Prescription Drugs may be subject to more restrictive day-supply and allowed quantity limitations. In addition, certain Prescription Drugs may not be available under this Plan by mail order due to circumstances such as unstable shelf life, and required special storage conditions.

IV. Amount Of Payment

BCI or one (1) of its designated claims processing vendors, will provide the following benefits for Covered Services:

A. The amount of payment for a covered Prescription Drug dispensed by a Participating Pharmacist is the balance remaining after subtracting the Prescription Drug Copayment, Cost-sharing and/or Deductible, if applicable, from the lower of the Allowed Charge or the Usual Charge for the Prescription Drug.

B. For a covered Prescription Drug dispensed by a Physician or a Licensed Pharmacist who is not a Participating Pharmacist, the Participant is responsible for paying for the Prescription Drug at the time of purchase and must submit a claim to BCI or one (1) of its designated claims processing vendors. The amount of payment for a covered Prescription Drug is the balance remaining after subtracting the Prescription Drug Copayment, Cost-sharing and/or Deductible, if applicable, from the lower of the Allowed Charge or the Usual Charge for the Prescription Drug.

C. The amount of payment for a covered Prescription Drug dispensed by a mail order Participating Pharmacy is the balance remaining after subtracting the Prescription Drug Copayment, Cost-sharing and/or Deductible, if applicable, from the lower of the Allowed Charge or the Usual Charge for the Prescription Drug.

D. Submission of a prescription to a pharmacy is not a claim. If a Participant receives Covered Services from a pharmacy and believes that the Copayment, Cost-sharing or other amount is incorrect, the Participant may then submit a written claim to BCI requesting reimbursement of any amounts the Participant believes were incorrect. Refer to the Inquiry And Appeals Procedures in the General Provisions Section of this Plan.

V. Mandatory Generic Drug Substitution

Certain Prescription Drugs are restricted to Generics for payment by BCI. Even if the Participant, the Physician or other duly licensed Provider requests the Brand Name Drug, the Participant is responsible for the difference between the price of the Generic and Brand Name Drug, plus any applicable Brand Name Drug Deductible/Copayment/Cost-sharing. The difference between the price of the Generic and Brand Name Drug shall not apply to the applicable Deductible and/or Out of Pocket Limits.

VI. Utilization Review

Prescription Drug benefits include utilization review of Prescription Drug usage for the Participant's health and safety. If there are patterns of over-utilization or misuse of drugs the Participant's personal Physician and Pharmacist will be notified. BCI, on behalf of the Trust, reserves the right to limit benefits to prevent over-utilization or misuse of Prescription Drugs.

VII. Prior Authorization

Certain Prescription Drugs may require Prior Authorization. If the Participant's Physician or other Provider prescribes a drug, which requires Prior Authorization, the Participant will be informed by the Provider or Pharmacist. To obtain Prior Authorization the Participant's Physician must notify BCI or its designated agent, describing the Medical Necessity for the prescription. BCI or its designated agent, will respond to a request for Prior Authorization received from either the Participant's Physician or the Participant within seventy-two (72) hours for an expedited request or fourteen (14) days for a standard request of the receipt of the medical information necessary to make a determination.

VIII. Covered Services

As listed on the Formulary, Generic and Brand Name Prescription Drugs, certain allowed Compound Drugs and Diabetic Supplies. The drugs or medicines must be directly related to the treatment of an Illness, Disease, medical condition or Accidental Injury and must be dispensed pursuant to a written prescription by a Licensed Pharmacist or Physician on or after the Participant's Effective Date. Benefits for Prescription Drugs are available up to the limits stated in Item III. of this section.

A. Smoking cessation Prescription Drugs are a Covered Service.

IX. Definitions

A. **Allowed Charge**—the amount payable for a Prescription Drug as determined by the reimbursement formula agreed upon between the Participating Pharmacist and one (1) or more of BCI's designated claims processing vendors.

B. **Brand Name Drug**—a Prescription Drug, approved by the FDA, that is protected by a patent and is marketed and supplied under the manufacturer's brand name.

C. **Compound Drug**—a customized medication derived from two or more raw chemicals, powders or devices, of which at least one ingredient is a federal legend drug, prepared by a Pharmacist according to a prescriber's specifications.

D. **Diabetic Supplies**—supplies that can be purchased at a Participating Pharmacy using the Participant's pharmacy benefit. Includes: insulin syringes, insulin pen needles, lancets, test strips (blood glucose and urine), and insulin pump supplies (reservoirs and syringes, administration sets, and access sets).

E. **Formulary**—a list of Covered Prescription Drugs approved by Blue Cross of Idaho's Pharmacy and Therapeutics Committee. This list is managed and subject to periodic review and amendment by the Pharmacy and Therapeutics Committee.

Prescription Drugs covered by the Prescription Drug Benefit are classified into one of the tiers as follows.

First Tier – Covered Preferred Generic Drugs.

Second Tier – Covered Non-Preferred Generic Drugs.

Third Tier – Covered Preferred Brand Name Drugs.

Fourth Tier – Covered Non-Preferred Brand Name Drugs.

Fifth Tier – Covered Preferred Specialty Drugs and Covered Generic Specialty Drugs.

Sixth Tier – Covered Non-Preferred Specialty Drugs.

ACA Preventive Drugs – ACA Mandated Preventive Drugs.

F. **Generic Drug**—a Prescription Drug, approved by the FDA, that has the same active ingredients, strength, and dosage as its Brand Name Drug counterpart.

G. **Nonparticipating Pharmacy/Pharmacist**—a Licensed Pharmacist, a retail, mail-order or Specialty Pharmacy that has not entered into a contract with one (1) or more of BCI's designated claims processing vendors for the purpose of providing Prescription Drug Covered Services to Participants under this Plan.

H. **Participating Pharmacy/Pharmacist**—a Licensed Pharmacist, a retail, mail-order or Specialty Pharmacy that has a contract with one (1) or more of BCI's designated claims processing vendors for the purpose of providing Prescription Drug Covered Services to Participants under this Plan.

I. **Pharmacy And Therapeutics Committee**—a committee of Physicians and Licensed Pharmacists established by BCI that recommends policy regarding the evaluation, selection, and therapeutic use of various drugs. The Committee also decides which drugs are eligible for benefits under this Plan.

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

K. **Specialty Drugs**—are injectable and non-injectable medications that are typically used to treat complex conditions and meet one or more of the following criteria:
   a. are biotech-derived or biological in nature;
   b. are significantly higher cost than traditional medications;
   c. are used in complex treatment regimens; require special delivery, storage and handling;
   d. require special medication-administration training for patients;
   e. require on-going monitoring of medication adherence, side effects, and dosage changes;
   f. are available through limited-distribution channels;
   g. and may require additional support and coordinated case management.

L. **Specialty Pharmacy**—a duly licensed Pharmacy that primarily dispenses Specialty Drugs.

M. **Usual Charge**—the lowest retail price being charged by a Licensed Pharmacist for a Prescription Drug at the time of purchase by a Participant.

X. Prescription Drug Exclusions And Limitations

In addition to any other exclusions and limitations of this Plan, the following exclusions and limitations apply to this section and throughout the entire Plan, unless otherwise specified.

If a Participant receives a discount or other cost reduction, in any form, including but not limited to a coupon or discount card from a pharmaceutical manufacturer, pharmacy, other health care Provider, or cost-sharing from a prohibited third party organization, the cost reduction or amount discounted toward the purchase of the Prescription Drug will not be applied to the Participant's applicable Deductible amounts, and will not be applied to the Participant's Out of Pocket Limit for this Plan.

Blue Cross of Idaho prohibits direct or indirect payment by third parties unless it meets the standards set below.

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

Each of the following criteria must be met for BCI to accept a third party payment:

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

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

BCI will inform the Participant in writing of the reason for rejecting or otherwise refusing to treat a third party payment as a payment from the Participant and of the Participant's right to file a complaint with the Department of Insurance.

A. No benefits are provided for the following:

1. Drugs used for the termination of early pregnancy, and complications arising therefrom, except when required to correct an immediately life-endangering condition.
2. Over-the-counter drugs other than insulin, even if prescribed by a Physician. Notwithstanding this exclusion, BCI, through the determination of the BCI Pharmacy and Therapeutics Committee may choose to cover certain over-the-counter medications when Prescription Drug benefits are provided under this Plan. Such approved over-the-counter medications must be identified by BCI in writing and will specify the procedures for obtaining benefits for such approved over-the-counter medications. Please note that the fact a particular over-the-counter drug or medication is covered does not require BCI to cover or otherwise pay or reimburse the Participant for any other over-the-counter drug or medication.
3. Charges for the administration or injection of any drug, except for vaccinations listed on the Prescription Drug Formulary.
4. Therapeutic devices or appliances, including hypodermic needles, syringes, support garments, and other non-medicinal substances except Diabetic Supplies, regardless of intended use.
5. Drugs labeled "Caution—Limited by Federal Law to Investigational Use," or experimental drugs, even though a charge is made to the Participant.
6. Immunization agents, except for vaccinations listed on the Prescription Drug Formulary, biological sera, blood or blood plasma. Benefits may be available under the Medical Benefits Section of this Plan.
7. Medication that is to be taken by or administered to a Participant, in whole or in part, while the Participant is an Inpatient in a Licensed General Hospital, rest home, sanatorium, Skilled Nursing Facility, extended care facility, convalescent hospital, nursing home, or similar institution which operates or allows to operate on its premises, a facility for dispensing pharmaceuticals.
8. Any prescription refilled in excess of the number specified by the Physician, or any refill dispensed after one (1) year from the Physician's original order.
9. Any Prescription Drug, biological or other agent, that is:
    a) Prescribed primarily to aid or assist the Participant in weight loss, including all anorectics, whether amphetamine or nonamphetamine.
    b) Prescribed primarily to retard the rate of hair loss or to aid in the replacement of lost hair.
    c) Prescribed primarily to increase fertility, including but not limited to, drugs which induce or enhance ovulation.
    d) Prescribed primarily for personal hygiene, comfort, beautification, or for the purpose of improving appearance.
    e) Prescribed primarily to increase growth, including but not limited to, growth hormone.
    f) Provided by or under the direction of a Home Intravenous Therapy Company, Home Health Agency or other Provider approved by BCI. Benefits are available for this Therapy Service under the Major Medical Benefits Section of this Plan only as preauthorized and approved when Medically Necessary.
10. Lost, stolen, broken or destroyed medications, except in the case of loss due directly to a natural disaster.

ELIGIBILITY AND ENROLLMENT SECTION

Family and Medical Leave Act.

Employees of employers subject to the Family and Medical Leave Act (FMLA) may be entitled to up to 12 weeks of unpaid, job-protected leave per year. For those employees eligible for leave under the FMLA, group health benefits may be maintained on the same terms and conditions as if the employee had been continuously employed during the leave.

- If the employee pays a portion of the contribution for group health plan benefit coverage and FMLA leave is paid, the employee's paycheck will continue to be reduced by an amount necessary to pay for the employee's share of the cost of coverage. If the employee does not want to receive the same group health plan benefit coverage during FMLA leave that the employee was receiving just prior to leave, the employee must inform the employer before the leave starts.
- If the employee decides not to receive group health plan benefits during FMLA leave, the employee will be reinstated in these group health plan benefits upon returning to work at the end of FMLA leave.
- If FMLA leave is unpaid and the employee wishes to continue participation in the Plan, the employee must make arrangements with the employer to pay for the coverage that the employee wishes to maintain during the course of leave. Eligibility to continue any coverage that requires payments from the employee may be cancelled if the employee does not make the required payments during the period of FMLA leave.
- If the employer advances money by making any or all of these required payments for the employee, the employer can recoup the amounts advanced through payroll deductions upon the employee's return to employment following FMLA leave to the extent permitted by law.
- If the employee fails to return from FMLA leave, and the reasons for failure are not beyond the employee's control, the employee is indebted to the employer for the full amount of the cost of health coverage provided during FMLA leave. The employer may deduct any such amounts owed by the employee from any compensable time payments owed to the employee upon termination for failure to return from an FMLA leave to the extent permitted by law.
- The employee should consult with the employer before embarking on any FMLA qualified leave.

If Plan coverage terminates during the FMLA leave, coverage for benefits under this Plan will be reinstated for the employee and the employee's covered dependents if the employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the employee or the employee's dependent(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated.

I. Eligibility and Enrollment

All Eligible Employees will have the opportunity to apply for coverage under this Plan.

A. Eligible Employee

Qualifications for eligibility are shown in the Benefits Outline.

B. Eligible Dependent

To qualify as an Eligible Dependent under this Plan, a person must be and remain one (1) of the following:

1. The Participating Employee's spouse under a legally valid marriage.

2. The Participating Employee's natural child, stepchild, legally adopted child, child placed with the Participating Employee for adoption, or child for whom the Participating Employee or the Participating Employee's spouse has court-appointed guardianship or custody. The child must be:
   a) Under the age of twenty-six (26); or
   b) Medically certified as disabled due to intellectual disability or physical handicap *and* financially dependent upon the Participating Employee for support, regardless of age.

3. A Participating Employee must notify the Idaho AGC Self-Funded Benefit Trust within thirty (30) days when a dependent no longer qualifies as an Eligible Dependent. Coverage for the former Eligible Dependent will terminate the last day of the month in which the change in eligibility status took place.

C. Annual Open Enrollment Periods

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

D. Initial Enrollment Period

The Initial Enrollment Period is thirty (30) days for Eligible Employees and Eligible Dependents. The Initial Enrollment Period begins on the date the Eligible Employee or Eligible Dependent first becomes eligible for coverage under this Plan.

E. Enrollment of Eligible Dependents

1. For an Eligible Employee to enroll himself or herself and any Eligible Dependents for coverage under this Plan (or for a Participant to enroll Eligible Dependents for coverage) the Eligible Employee or Participant, as the case may be, must complete an application and submit it to the Trust.

2. Newborn/Adoption ---When a newborn child is added and the monthly contribution changes, a full month's contribution is required for the child if his or her date of birth falls on the first (1^{st}) through the fifteenth (15^{th}) day of the month. No contribution is required if the child's date of birth falls on the sixteenth (16^{th}) through the last day of the month. A Participant's newborn Dependent, including adopted newborn children who are placed with the adoptive Participant within sixty (60) days of the adopted child's date of birth, are covered under this Plan from and after the date of birth for 60 days.

   A. Contribution for the first sixty (60) days of coverage is due not less than thirty-one (31) days following receipt of a billing for the required contribution. In order to continue coverage beyond the sixty (60) days outlined above, the Participant must complete an enrollment application within sixty (60) days of date of birth and submit the required contribution, for the first sixty (60) days, within thirty-one (31) days of the date monthly billing is received and a notice of contribution is provided to the Participant from the Employer.

   B. If the date of adoption or the date of placement for adoption of a child is more than sixty (60) days after the child's date of birth, the Effective Date of coverage will be the date of adoption or the date of placement for adoption. In this Plan, 'child' means an individual who has not attained age eighteen (18) years as of the date of the adoption or placement for adoption. In this Plan, "placed for adoption" means physical placement in the care of the adoptive Participant, or in those circumstances in which such physical placement is prevented due to the medical needs of the child requiring placement in a medical facility, it means when the adoptive Participant signs an agreement for adoption of the child and signs an agreement assuming financial responsibility for the child.

F. Effective Dates of Coverage

Subject to receiving the applicable contribution payment:

1. If the Eligible Employee or Eligible Dependent enrolled in this Plan during their Initial Enrollment Period or the Employer's Open Enrollment Period, the Effective Date of coverage for an Eligible Employee and any Eligible Dependents listed on the Eligible Employee's application is the Employer's Plan Date if the application is submitted to the Trust by the Employer on or before the Plan Date.

2. Except as provided otherwise in this section, if enrollment is requested during an Initial Enrollment Period or annual Open Enrollment Period, the Effective Date of coverage for an Eligible Employee or an Eligible Dependent will be the first day of the month following the month of enrollment.

3. If enrollment is requested during a Special Enrollment Period due to the loss of Minimum Essential Coverage or marriage, the Effective Date of coverage will be the first day of the month following the marriage or loss of coverage.

4. The Effective Date of coverage for enrollment requested during a Special Enrollment Period will be the date of birth for a newborn natural child or a newborn child adopted or placed for adoption within sixty (60) days of the child's date of birth.

5. For other enrollment requested though a Special Enrollment Period, if the application is received between the first and fifteenth day of the month, coverage will begin on the first day of the

following month. If the application is received between the sixteenth day and the last day of the month, coverage will begin on the first day of the second month.

G. Late Participant

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

H. Special Enrollment Periods

Outside of the Eligible Employee's Initial Enrollment Period or annual Open Enrollment Period, an Eligible Employee or Eligible Dependent will not be considered a Late Participant and may enroll for coverage, unless otherwise noted, within thirty (30) days of the occurrence of one of the following events:

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

II. Special Rules for Hour Bank Employees

Hours credited to the Eligible Employee's Hour Bank account will be used to purchase health benefits coverage for the month immediately following. The charge to the Eligible Employee's Hour Bank account will be 140 hours for one month's coverage. Once the Eligible Employee becomes eligible, if the Hour Bank account has less than 140 hours, they will be notified by the Administration Office that coverage will cease and they will have the opportunity to self-pay the difference between the number of hours in the account and 140 hours so that health benefits coverage can be continued for that month. The amount required to be paid will be the amount determined by multiplying the Plan's then current Hour Bank withdrawal rate times the number of hours that the Eligible Employee's account is less than 140. The Hour Bank withdrawal rate is a dollar amount per hour established each year by the Plan for the payment of the monthly health benefits contribution from an Hour Bank account. If the employer is covered by COBRA, the Eligible Employee also will be notified of the right to elect COBRA continuation coverage following termination of active coverage. The Eligible Employee's remaining Hour Bank Coverage and COBRA coverage will run concurrently. If they do not elect to self-pay the difference in the 140 hours and, if eligible for COBRA, if they do not elect COBRA, the Eligible Employee's coverage will cease as of the end of the last month for which a full charge of 140 hours was made. If the Eligible Employee is eligible for COBRA, COBRA will commence immediately following the last month for which they have Hour Bank coverage. Generally, self-pay coverage and COBRA coverage must be continuous and immediately following any prior active coverage and the Eligible Employee may not have a break in coverage in one or more months and then elect self-pay or COBRA coverage for one or more months that are not continuous with prior active coverage.

Starting January 1, 2013, there is an eighteen (18) month cap on the amount of coverage that the Eligible Employee can accumulate in the Hour Bank account. If they accumulate or have accumulated more than eighteen (18) months coverage in the Hour Bank account, any excess will be paid out to the Eligible Employee within a reasonable period of time following March 31 of each year. If the Eligible Employee (a) terminates employment with the employer, or (b) changes jobs with the employer to a different job classification that is not Hour Bank employment, the Eligible Employee's health benefits coverage under the Plan will continue so long as there is a sufficient balance in the Hour Bank account to provide such coverage. If the Eligible Employee changes jobs with the employer to a different job classification that is not Hour Bank employment, but is covered under this Plan, the Hour Bank account will be held

for use at a future time when the Eligible Employee is either no longer employed, not covered under this Plan, or has returned to Hour Bank employment. Once the balance falls below 140 hours, the Eligible Employee will be notified by the Administration Office and will be given the opportunity to self-pay any difference between the amount in the Hour Bank account and 140 hours, and, if eligible for COBRA, to elect COBRA continuation coverage as described above. Self-pay coverage and COBRA continuation coverage for former employees must be continuous and immediately following any prior active coverage. Any Hour Bank account balance of less than 140 hours that is not used within four (4) months of the last date of coverage will be forfeited to the Trust. If the Eligible Employee has an Hour Bank account balance of less than 140 hours and returns to Hour Bank employment and the Eligible Employee either self pays or is credited with sufficient hours to have at least 140 hours in their Hour Bank account within four (4) months of the last date of coverage, they will receive health benefits coverage under the Trust for the next following month. If the employer ceases to participate in the Trust as a participating employer, health benefits coverage under the Trust will not continue, and the Eligible Employee will not be eligible to continue coverage under the Trust through self-payment under COBRA or through purchasing coverage by exhausting his or her Hour Bank. If the employer ceases to participate in the Trust as a participating employer, any balance remaining in an Eligible Employee's Hour Bank will be paid out to the Eligible Employee on the employer's termination.

III. Employer Contribution and Enrollment Requirements

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

The Employer agrees to be responsible for and make the total required payment to the Trust. The Employer further agrees that no other hospital, medical or surgical group coverage will be offered to employees during the term of this Plan, unless required by State or Federal law.

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

C. Before the Effective Date of the change, the Employer shall submit all eligibility changes for Participants and Eligible Dependents on the Trust forms. It is the Employer's responsibility to verify that all Participants are eligible for coverage as specified in this Plan. The Trust shall have the right to audit the Employer's employment, payroll, and eligibility records to ensure that all Participants are eligible and properly enrolled and to ensure that the Employer meets enrollment requirements.

D. This Plan is issued to the Employer upon the express condition that a pre-established required percentage of the Eligible Employees specified in the Application for Employer Coverage who meet the underwriting criteria of the Trust are and continue to be Participants. This Plan is issued upon the express condition that the Employer continues to make the employer contribution specified in the Application for Employer Coverage and this Plan. The Trust may terminate this Plan if the percentage of Eligible Employees as Participants or the percentage of the employer contribution drops below the required level.

E. If the Employer maintains regular monthly payments with the regular Employer billing, an employer approved temporary leave of absence may continue for a maximum of three (3) months and then cease. On its regular billing, the Employer will notify the Trust of the Participant's date of departure for the leave of absence, and shall continue its regular contribution for the Participant's coverage during the leave of absence.

IV. Qualified Medical Child Support Order

A. If this Plan provides for Family Coverage, BCI, on behalf of the Trust, will comply with a Qualified Medical Child Support Order (QMCSO) according to the provisions of Section 609 of ERISA and any other applicable federal or state laws. A medical child support order is any judgement, decree, or order (including approval of a settlement agreement) issued by a court of competent jurisdiction that:

1. Provides for child support with respect to a child of a Participating Employee or provides for health benefit coverage to such a child, is made pursuant to a state domestic relations law (including a community property law) and relates to benefits under this Plan**,** or
2. Enforces a law relating to medical child support described in Section 1908 of the Social Security Act with respect to a group health plan.

B. A medical child support order meets the requirements of a QMCSO if such order clearly specifies:

1. The name and the last known mailing address (if any) of the Participating Employee and the name and mailing address of each child covered by the order.

2. A reasonable description of the type of coverage to be provided by this Plan to each such child, or the manner in which such type of coverage is to be determined.

3. The period to which such order applies.

C. 1. Within fifteen (15) days of receipt of a medical child support order, BCI will notify the party who sent the order and each affected child of the receipt and of the criteria by which BCI determines if the medical child support order is a QMCSO. In addition, BCI will send an application to each affected child. The application must be completed by or on behalf of the affected child and promptly returned to BCI. With respect to a medical child support order, affected children may designate a representative for receipt of copies of notices sent to each of them.

2. Within thirty (30) days after receipt of a medical child support order and a completed application, BCI will determine if the medical child support order is a QMCSO and will notify the Participating Employee, the party who sent the order, and each affected child of such determination.

D. BCI, on behalf of the Trust, will make benefit payments to the respective party for reimbursement of eligible expenses paid by an enrolled affected child or by an enrolled affected child's custodial parent, legal guardian, or the Idaho Department of Health and Welfare.

DEFINITIONS SECTION

For reference, most terms defined in this section are capitalized throughout this Plan. Other terms may be defined where they appear in this Plan**.** All Providers and Facilities must be licensed and/or registered by the state where the services are rendered, unless exempt by federal law, and must be performing within the scope of license in order for BCI to provide benefits. Definitions in this Plan shall control over any other definition or interpretation unless the context clearly indicates otherwise.

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

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

Administrative Services Agreement – a formal agreement between BCI and the Trust outlining responsibilities, general administrative services and benefit payment services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Benefit Period—the specified period of time during which a Participant accumulates annual benefit limits, Deductible amounts and Out-of-Pocket Limits.

Blue Cross Of Idaho Health Service, Inc. (Blue Cross of Idaho or BCI)—a nonprofit mutual insurance company, hired by the Board of Trustees to act as the Contract Administrator to perform claims processing and other specific administrative services as outlined in the Plan and/or Administrative Services Agreement.

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

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

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

The administration of the Plan document is under the supervision of the Board of Trustees. The Idaho Associated General Contractors (AGC) acts on behalf of the Board of Trustees. The Board of Trustees has agreed to indemnify each employee in the Idaho Associated General Contractor (AGC) for any liability he/she incurs as a result of acting on behalf of the Board of Trustees, except if such liability is due to his/her gross negligence or misconduct.

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

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

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

Chiropractic Physician—an individual licensed to practice chiropractic.

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

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

Clinical Psychologist—an individual licensed to practice clinical psychology.

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

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

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

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

Contracting Provider—a Provider that has entered into a written agreement with BCI regarding payment for rendered Covered Services rendered to a Participant under a Preferred Blue PPO program.

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

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

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

Covered Service—when rendered by a Provider, a service, supply, or procedure specified in this Plan for which benefits will be provided to a Participant.

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

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

Dentist—an individual licensed to practice Dentistry.

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

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

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

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

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

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

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

Effective Date—the date when coverage for a Participant begins under this Plan.

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

Eligible Dependent—a person eligible for enrollment under a Participating Employee's coverage. For the purposes of this Plan, the child of a Surrogate will not be considered an Eligible Dependent of the Surrogate or her spouse.

Eligible Employee—an employee, sole proprietor or partner of an Employer who is entitled to apply as a Participating Employee.

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

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

Emergency Medical Condition—a condition in which sudden and unexpected symptoms are sufficiently severe to necessitate immediate medical care. Emergency Medical Conditions, include but are not limited to, heart attacks, cerebrovascular accidents, poisonings, loss of consciousness or respiration, and convulsions.

Employer—any Employer participating in the Trust.

Family Coverage—the enrollment of a Participating Employee and two (2) or more Eligible Dependents under this Plan.

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

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

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

Health Benefit Plan—the Idaho AGC Self-Funded Benefit Trust. This coverage is not insurance and the Idaho AGC Self-Funded Benefit Trust does not participate in the State Guaranty Association.

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

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

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

Home Health Skilled Nursing Care Services—the delivery of Skilled Nursing Care services under the direction of a Physician to a Homebound Participant. Home Health Skilled Nursing is generally intended to transition a Homebound patient from a hospital setting to a home or prevent a hospital stay, provided such nurse does not ordinarily reside in the Participant's household or is not related to the Participant by blood or marriage.
Home Intravenous Therapy Company—a licensed, where required, and/or Medicare Certified (and/or otherwise acting under the scope of its license) pharmacy or other entity that is principally engaged in providing services, medical supplies, and equipment for certain home infusion Therapy Covered Services, to Participants in their homes or other locations outside of a Licensed General Hospital.

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

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

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

Hospital Grade Breast Pump—a stronger piston based breast pump that meets hospital requirements for electrical safety, cleaning and sterilization for rental between users. Typically used by a mother with a premature baby or a personal medical condition that affects milk production.

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

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

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

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

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

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

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

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

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

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

Licensed Clinical Professional Counselor (LCPC)—a licensed individual providing diagnosis and treatment of Mental or Nervous Conditions.

Licensed Clinical Social Worker (LCSW)—a licensed individual providing diagnosis and treatment of Mental or Nervous Conditions.

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

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

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

Licensed Pharmacist—an individual licensed to practice pharmacy.

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

Lifetime Benefit Limit—the greatest aggregate amount payable by BCI, on behalf of the Trust and on behalf of a Participant for specified Covered Services during all periods in which the Participant has been continuously enrolled or covered under any agreement, certificate, contract, or plan administered on behalf of the Idaho AGC, Self-Funded Benefit Trust. The Lifetime Benefit Limit shall only apply to Temporomandibular Joint (TMJ) Syndrome Services as shown in the Benefits Outline.

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

The Maximum Allowance is determined using many factors, including pre-negotiated payment amounts; diagnostic related groupings (DRGs); a resource based relative value scale (RBRVS); ambulatory payment classifications (APCs); the Provider's

charge(s); the charge(s) of Providers with similar training and experience within a particular geographic area; Medicare reimbursement amounts; and/or the cost of rendering the Covered Service. Moreover, Maximum Allowance may differ depending on whether the Provider is Contracting or Noncontracting.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Occupational Therapist—an individual licensed to practice occupational therapy.

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

Open Enrollment Period—the period of time chosen by the Employer, other than during an Initial Enrollment Period or Special Enrollment Period, in which an Eligible Employee and/or Eligible Dependent may enroll in an available Health Benefit Plan offered by their employer, usually once a year.

Ophthalmologist—a doctor of medicine (M.D.) who is both a medical doctor and a surgeon. The ophthalmologist is licensed to examine, diagnose and treat disorders and diseases of the eye and visual system of the brain, as well as prescribe corrective lenses (glasses or contacts).

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

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

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

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

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

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

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

Participant—a Participating Employee or an enrolled Eligible Dependent covered under this Plan**.**

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

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

Physical Therapist—an individual licensed to practice physical therapy.

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

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

Plan(s)—a self-insured program(s) maintained by the Trust for the purpose of providing health care benefits to the Plan Participants.

Plan Date—the date specified in this Plan on which coverage commences for the Employer.

Plan Sponsor—Idaho Branch Inc., Associated General Contractors of America, Inc.

Podiatrist—an individual licensed to practice podiatry.

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

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

Preferred Blue PPO—a preferred provider organization product offered through BCI.

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

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

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

Primary Care Provider—a Professional Provider who is generally the first contact when a Participant seeks medical treatment. Benefits may include services for infants and children, immunizations, screening for infectious and communicable diseases, treating minor injuries and common complaints, and managing chronic disease. A Primary Care Provider includes, but is not limited to, general/family practice, pediatrics, internal medicine, obstetric and gynecology.

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

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

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

Provider—a person or entity that is licensed, where required, to render Covered Services. For the purposes of this Plan, Providers include any facility or individual who provides a Covered Service while operating within the scope of their professional license and applicable state law, unless exempted by federal law.

1. Facility Providers
    a. Ambulatory Surgical Facility (Surgery Center)
    b. Alcoholism or Substance Abuse Treatment
    c. CLIA Certified, Independent Laboratory
    d. Home Intravenous Therapy Company
    e. Hospice
    f. Licensed Rehabilitation Hospital
    g. Psychiatric Hospital
    h. Diagnostic Imaging Provider
    i. Freestanding Diabetes Facility
    j. Freestanding Dialysis Facility
    k. Home Health Agency
    l. Licensed General Hospital
    m. Prosthetic and Orthotic Supplier
    n. Radiation Therapy Center
    o. Residential Treatment Facility

p. Skilled Nursing Facility

2. Professional Providers
   a. Ambulance Transportation Service
   b. Audiologist
   c. Certified Nurse-Midwife
   d. Certified Registered Nurse Anesthetist
   e. Chiropractic Physician
   f. Clinical Nurse Specialist
   g. Speech Therapist
   h. Clinical Psychologist
   i. Licensed Clinical Professional Counselor (LCPC)
   j. Licensed Clinical Social Worker (LCSW)
   k. Licensed Marriage and Family Therapist (LMFT)
   l. Licensed Occupational Therapist
   m. Licensed Physical Therapist
   n. Dentist/Denturist
   o. Durable Medical Equipment Supplier
   p. Licensed Pharmacist
   q. Nurse Practitioner
   r. Optometrist/Optician
   s. Physician
   t. Physician Assistant
   u. Registered Dietitian
   v. Podiatrist

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

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

Recognized Transplant Center—a Licensed General Hospital that meets any of the following criteria:
1. Is approved by the Medicare program for the requested Transplant Covered Services.
2. Is included in the Blue Cross and Blue Shield System's National Transplant Networks.
3. Has arrangements with another Blue Cross and/or Blue Shield Plan for the delivery of the requested Transplant Covered Services, based on appropriate approval criteria established by that Plan.
4. Is approved by BCI based on the recommendation of BCI's Medical Director.

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

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

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

Residential Treatment Facility (Program)—a licensed Facility Provider acting under the scope of its license primarily engaged in providing twenty-four (24) hour level of care that provides Participants with long-term or severe mental disorders or substance abuse-related disorders with residential care. Care includes treatment with a range of diagnostic and therapeutic behavioral health services that cannot be provided through existing community programs.

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

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

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

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

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

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

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

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

Specialist Provider—a Professional Provider with an MD or DO designation that has received specialized training and has been certified in a specialty recognized by the American Board of Medical Specialties (ABMS) including, but not limited to cardiology, dermatology, endocrinology, gastroenterology, neurology, etc. A Specialist Provider generally provides expert advice or treatment for conditions that are beyond the scope and training of a Primary Care Provider.

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

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

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

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

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

Therapeutic Boarding School—a boarding school which provides educational and emotional development programs.

Therapy Services—Therapy Services include only the following:

1. Radiation Therapy—treatment of Disease by x-ray, radium, or radioactive isotopes.
2. Chemotherapy—treatment of malignant Disease by chemical or biological antineoplastic agents.
3. Renal Dialysis—treatment of an acute or chronic kidney condition, which may include the supportive use of an artificial kidney machine.
4. Physical Therapy—treatment by physical means, hydrotherapy, heat or similar modalities, physical agents, biomechanical and neurophysiological principles, or devices to relieve pain, restore maximum function, or prevent disability following a condition, Disease, Illness, Accidental Injury, or loss of a body part.
5. Respiratory Therapy—treatments introducing dry or moist gases into the lungs.

6. Occupational Therapy—treatment that employs constructive activities designed and adapted for a physically disabled Participant to help him or her satisfactorily accomplish the ordinary tasks of daily living and tasks required by the Participant's particular occupational role.
7. Speech Therapy—corrective treatment of a speech impairment resulting from a condition, Illness, Disease, Surgery, or Accidental Injury; or from Congenital Anomalies, or previous therapeutic processes.
8. Growth Hormone Therapy—treatment administered by intramuscular injection to treat children with growth failure due to pituitary disorder or dysfunction.
9. Home Intravenous Therapy (Home Infusion Therapy)—treatment provided in the home of the Participant or other locations outside of a Licensed General Hospital, that is administered via an intravenous, intraspinal, intra-arterial, intrathecal, subcutaneous, enteral, or intramuscular injection or access device inserted into the body, at or under the direction of a Home Health Agency or other Provider approved by BCI.

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

Trust—the Idaho AGC Self-Funded Benefit Trust, also the Board of Trustees.

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

EXCLUSIONS AND LIMITATIONS SECTION

In addition to the exclusions and limitations listed elsewhere in this Plan, the following exclusions and limitations apply to the entire Plan, unless otherwise specified.

I. General Exclusions and Limitations

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

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

B. In excess of the Maximum Allowance.

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

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

E. Investigational in nature.

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

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

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

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

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

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

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

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

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

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

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

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

Q. For telephone consultations; and all computer or Internet communications, except as specified as a Covered Service in this Plan.

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

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

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

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

V. Related to Dentistry or Dental Treatment, even if related to a medical condition; or Orthoptics, eyeglasses or Contact Lenses, or the vision examination for prescribing or fitting eyeglasses or Contact Lenses, unless specified as a Covered Service in this Plan**.**

W. For hearing aids or examinations for the prescription or fitting of hearing aids.

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

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

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

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

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

AC. Incurred by an Eligible Dependent child for care or treatment of any condition arising from or related to pregnancy, childbirth, delivery, or an Involuntary Complication of Pregnancy, unless specifically provided as a Covered Service in this Plan.

AD. For any of the following:

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

AE. For weight control or treatment of obesity or morbid obesity, even if Medically Necessary, including but not limited to Surgery for obesity. For reversals or revisions of Surgery for obesity, except when required to correct a life-endangering condition.

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

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

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

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

AJ. For acupuncture.

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

AL. For Hospice, except as specified as a Covered Service in this Plan.

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

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

AO. For the treatment of injuries sustained while committing a felony, voluntarily taking part in a riot, or while engaging in an illegal act or occupation, unless such injuries are a result of a medical condition or domestic violence.

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

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

AQ. Any services or supplies for which a Participant would have no legal obligation to pay in the absence of coverage under this Plan or any similar coverage; or for which no charge or a different charge is usually made in the absence of health benefits or insurance coverage or for which reimbursement or payment is contemplated under an agreement entered into with a third party.

AR. For a routine or periodic mental or physical examination that is not connected with the care and treatment of an actual Illness, Disease or Accidental Injury or for an examination required on account of employment; or related to an occupational injury; for a marriage license; or for insurance, school or camp application; or for sports participation physicals; or a screening examination including routine hearing examinations, unless specified as a Covered Service under this Plan.

AS. For immunizations except as specifically provided as a Covered Service in the Plan.

AT. For breast reduction Surgery or Surgery for gynecomastia.

AU. For nutritional supplements.

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

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

AX. For an elective abortion, except to preserve the life of the female upon whom the abortion is performed, unless benefits for an elective abortion are specifically provided by a separate Endorsement to this Plan**.**

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

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

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

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

AAC. For outpatient pulmonary and/or outpatient cardiac Rehabilitation, except as specified as a Covered Service under this Plan.

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

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

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

AAG. For arch supports, orthopedic shoes, and other foot devices.

AAH. For wigs.

AAI. For cranial molding helmets, unless used to protect post cranial vault surgery.

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

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

AAL. Any services or supplies furnished by a Therapeutic Boarding School, a facility that is primarily a health resort, sanatorium, or transitional living center.

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

AAN. Any newly FDA approved Prescription Drug, biological agent, or other agent until it has been reviewed and implemented by BCI's Pharmacy and Therapeutics Committee.

AAO. For the treatment of injuries sustained while operating a motor vehicle under the influence of alcohol and/or narcotics. For purposes of this Plan exclusion, "Under the influence" as it relates to alcohol means having a whole blood alcohol content of .08 or above or a serum blood alcohol content of .10 or above as measured by a laboratory approved by the State Police or a laboratory certified by the Centers for Medicare and Medicaid

Services. For purposes of this Plan exclusion, "Under the influence" as it relates to narcotics means impairment of driving ability caused by the use of narcotics not prescribed or administered by a Physician.

AAP. Rendered after exhaustion of an established benefit limit, unless authorized at the discretion of the Plan Sponsor and in accordance with specific BCI medical criteria.

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

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

II. Preexisting Condition Waiting Period

There is no preexisting condition waiting period for benefits available under this Plan.

GENERAL PROVISIONS SECTION

I. Termination or Modification of a Participant's Coverage Under this Plan

A. If a Participating Employee ceases to be an Eligible Employee or the Employer does not remit the required contribution, the Participating Employee's coverage and the coverage of any and all enrolled Eligible Dependents will terminate on the last day of the last month for which payment was made. If the Employer does not remit the required payments as required by the Participation agreement and the Trust elects to elects to terminate this Employer's Agreement, the Participating Employee's coverage and the coverage of any and all enrolled Eligible Dependents will terminate on the last day for which the Employer reimbursed the Trust.

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

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

D. Except as otherwise provided in this Plan, no benefits are available to a Participant for Covered Services rendered after the date of termination of a Participant's coverage.

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

F. Prior to legal finalization of an adoption, the coverage provided in this Plan for a child placed for adoption with a Participating Employee continues as it would for a naturally born child of the Participating Employee until the first of the following events occurs:

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

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

G. Coverage under this Plan will terminate for an Eligible Dependent on the last day of the month he or she no longer qualifies as an Eligible Dependent due to a change in eligibility status.

II. COBRA and ERISA Compliance

BCI is not the plan administrator for compliance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and any amendments to it; nor is BCI the plan administrator for the Employee Retirement Income Security Act (ERISA) and any amendments to it. Except for services BCI has agreed to perform regarding COBRA, the Trust is responsible for satisfaction of notice, disclosure, and other obligations if these laws are applicable to the Employer.

III. Contract Between BCI and The Trust—Description Of Coverage

This Plan is a contract between BCI and the Trust. The Trust will provide the Employer with copies of the Plan to give to each Participating Employee as a description of coverage or provide electronic access to the Plan, but this Plan shall not be construed as a contract between BCI or the Trust and any Participating Employee. The Trust's mailing or any other delivery of this Plan to the Employer constitutes complete and conclusive issuance and delivery thereof to each Participating Employee.

IV. Applicable Law

This Plan shall be governed by and interpreted according to the laws of the state of Idaho.

V. Benefits to Which Participants Are Entitled

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

B. In the event of an Inpatient Admission that occurs prior to the Employer's transfer to the Trust and the Effective Date of coverage under this Plan, benefits will be provided only when the Participant receives services that are Covered Services under this Plan. The outgoing carrier has primary responsible for providing benefits for the Inpatient treatment from the date of admission until the first of the following events occur:

- The Participant is discharged,
- The Benefit Period under the previous coverage ends, or
- Until benefits under the outgoing carrier's policy are exhausted.

BCI will provide benefits for Covered Services incurred following the Effective Date of coverage reduced by the benefits paid by the outgoing carrier.

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

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

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

VI. Notice Of Claim

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

VII. Release and Disclosure of Medical Records and Other Information

A. In order to effectively apply the provisions of this Plan, BCI may obtain information from Providers and other entities pertaining to any health related services that the Participant may receive or may have received in the past. BCI may also disclose to Providers and other entities, information obtained from the Participant's transactions such as policy coverage, contributions, payment history and claims data necessary to allow the processing of a claim and for other health care operations. To protect the Participant's privacy, BCI treats all information in a confidential manner. For further information regarding BCI's privacy policies and procedures, the Participant may request a copy of BCI's Notice of Privacy Practices by contacting Customer Service at the number provided in this Plan.

B. As a condition of coverage under this Plan, each Participant authorizes Providers to testify at BCI's request as to any information regarding the Participant's medical history, services rendered, and treatment received. Any and all provisions of law or professional ethics forbidding such disclosures or testimony are waived by and in behalf of each Participant.

VIII. Exclusion of General Damages

Liability under this Plan for benefits conferred hereunder, including recovery under any claim or breach of this Plan, shall be limited to the actual benefits for Covered Services as provided herein and shall specifically exclude any claim for general damages, including but not limited to, alleged pain, suffering or mental anguish, or for economic loss, or consequential loss or damages.

IX. Payment of Benefits

Blue Cross of Idaho provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

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

B. Blue Cross of Idaho prohibits direct or indirect payment by third parties unless it meets the standards set below.

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

Each of the following criteria must be met for BCI to accept a third party payment:

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

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

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

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

X. Participant/Provider Relationship

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

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

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

XI. Participating Plan

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

XII. Coordination of this Plan's Benefits with Other Benefits

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

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

A. Definitions

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

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

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

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

3. The Order of Benefit Determination Rules determine whether This Contract is a Primary Contract or Secondary Contract when the Participant has health care coverage under more than one (1) Contract. When This Contract is primary, it determines payment for its benefits first before those of any other Contract without considering any other Contract's benefits. When This Contract is secondary, it determines its benefits after those of another Contract and may reduce the benefits it pays so that all Contract benefits do not exceed one hundred percent (100%) of the total Allowable Expense.

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

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

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

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

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

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

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

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

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

B. Order of Benefit Determination Rules

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

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

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

   b) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Contract provided by the Contract holder.

Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.

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

4. Each Contract determines its order of benefits using the first of the following rules that apply:

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

b) Dependent Child Covered Under More Than One Contract. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Contract the order of benefits is determined as follows:

(1) For a dependent child whose parents are married or are living together, whether or not they have ever been married: The Contract of the parent whose birthday falls earlier in the calendar year is the Primary Contract; or If both parents have the same birthday, the Contract that has covered the parent the longest is the Primary Contract.

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

i. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Contract of that parent has actual knowledge of those terms, that Contract is primary. This rule applies to Contract year commencing after the Contract is given notice of the court decree;

ii. If a court decree states that both parents are responsible for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (1) shall determine the order of benefits;

iii. If a court decree states both parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage, the provisions of Subparagraph (1) above shall determine the order of benefits;

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

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

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

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

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

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

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

C. Effect on the Benefits of this Contract

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

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

D. Facility of Payment

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

E. Right of Recovery

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

XIII. Benefits for Medicare Eligibles Who Are Covered Under this Plan

A. If the Employer has twenty (20) or more employees, any Eligible Employee or spouse of an Eligible Employee who becomes or remains a Participant of the Employer covered by this Plan after becoming eligible for Medicare (due to reaching age sixty-five (65)) is entitled to receive the benefits of this Plan as primary.

B. If the Employer has one hundred (100) or more employees or the Employer is an organization which includes an employer with one hundred (100) or more employees, any Eligible Employee, spouse of an Eligible Employee or dependent child of an Eligible Employee who becomes or remains a Participant of the Employer covered by this Plan after becoming eligible for Medicare due to disability is entitled to receive the benefits of this Plan as primary.

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

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

XIV. Incorporated by Reference

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

XV. Inquiry and Appeals Procedures

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

A. Informal Inquiry

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

B. Formal Appeal

A Participant who wishes to formally appeal a Pre-Service Claim decision by BCI, on behalf of the Trust, may do so through the following process:

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

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

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

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

5. If the original, non-urgent claim decision is upheld upon reconsideration, the Participant may send an additional written appeal to the Appeals and Grievance Coordinator requesting further review. This appeal must set forth the reasons for requesting additional reconsideration and must be sent

within thirty (30) days of BCI's mailing of the initial reconsideration decision. A BCI Medical Director who is not subordinate to the Medical Director or physician designee who decided the initial appeal, will issue a final decision after consideration of all relevant information. A final decision on the appeal will be made within fifteen (15) days of its receipt.

C. A Participant who wishes to formally appeal a Post-Service Claims decision by BCI, on behalf of the Trust, may do so through the following process:

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

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

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

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

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

D. Participant's Rights to an Independent External Review

Please read this carefully. It describes a procedure for review of a disputed health claim by a qualified professional who has no affiliation with BCI. If a Participant or their authorized representative requests an independent external review of a claim, the decision made by the independent reviewer will be binding and final on the Trust. The Participant or their authorized representative will have the right to further review the claim by a court, arbitrator, mediator or other dispute resolution entity only if your plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), as more fully explained below under "Binding Nature of the External Review Decision."

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

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

A Participant must first exhaust BCI's internal grievance and appeal process. Exhaustion of that process includes completing all levels of appeal. Exhaustion of the appeals process is not required if BCI failed to respond to a standard appeal within thirty-five (35) days in writing or to an urgent appeal within three business days of the date the Participant filed the appeal, unless the Participant requested or agreed to a

delay. BCI may also agree to waive the exhaustion requirement for an external review request. The Participant may file for an internal urgent appeal with BCI and for an expedited external review with the Idaho Department of Insurance at the same time if the Participant's request qualifies as an "urgent care request" defined below.

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

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

For more information and for an external review request form:

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

A Participant may act as their own representative in a request or a Participant may name another person, including a Participant's treating health care provider, to act as an authorized representative for a request. If a Participant wants someone else to represent them, a Participant must include a signed BCI's "Appointment of an Authorized Representative" form with the request before BCI, on behalf of the Trust, determines that an individual has been authorized to act on behalf of the Participants. The form can be found on BCI's Web site www.bcidaho.com. A Participant's written external review request to the Department of Insurance must include a completed form authorizing the release of any medical records the independent review organization may require to reach a decision on the external review, 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 a Participant's completed authorization form. If the request qualifies for external review, BCI's final Adverse Benefit Determination will be reviewed by an independent review organization selected by the Department of Insurance. The Trust will pay the costs of the review.

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

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

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

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

1. Could seriously jeopardize the life or health of the Participant or the ability of the Participant to regain maximum function;

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

The Department of Insurance will send your request to us. BCI will determine, no later than the second (2^{nd}) full business day, if the request is eligible for review. BCI will notify the Participant and the Department of Insurance no later than one (1) business day after BCI's decision if the request is eligible. If BCI denies the eligibility for review, the Participant may appeal that determination to the Department of Insurance.

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

Binding Nature of the External Review Decision:
The Trust is subject to the federal Employee Retirement Income Security Act (ERISA) laws (generally, any plan offered through an employer to its employees), the external review decision by the independent review organization will be final and binding on the Trust. The Participant may have additional review rights provided under federal ERISA laws.

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

XVI. Reimbursement of Benefits Paid by Mistake

If BCI mistakenly makes payment for benefits on behalf of a Participating Employee or his or her Eligible Dependent(s) that the Participating Employee or his or her Eligible Dependent(s) is not entitled to under this Plan, the Participating Employee must reimburse the erroneous payment to BCI, on behalf of the Trust.

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

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

XVII. Subrogation and Reimbursement Rights of Blue Cross of Idaho

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

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

Blue Cross of Idaho, on behalf of the Trust may at its option elect to enforce either or both of its rights of subrogation and reimbursement.

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

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

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

To the extent that Blue Cross of Idaho, on behalf of the Trust provides or pays benefits for Covered Services, Blue Cross of Idaho's rights of subrogation and reimbursement extend to any right the Participant has to recover from the Participant's insurer, or under the Participant's "Medical Payments" coverage or any "Uninsured Motorist," "Underinsured Motorist," or other similar coverage provisions, and workers' compensation benefits.
Blue Cross of Idaho, on behalf of the Trust shall have the right, at its option, to seek reimbursement from, or enforce its right of subrogation against, the Participant, the Participant's personal representative, a special needs trust, or any trust, person or vehicle that holds any payment or recovery from or on behalf of the Participant including the Participant's attorney.

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

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

XVIII. Statements

In the absence of fraud, all statements made by an applicant, or the Trust, or by an enrolled Participant shall be deemed representations and not warranties, and no statement made for the purpose of acquiring insurance shall void such coverage or reduce benefits unless contained in a written instrument signed by the Trust or the Participant.

XIX. Out-of-Area Services

Overview

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

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

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

A. BlueCard® Program

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

1. Liability Calculation Method Per Claim – In General

a. Participant Liability Calculation

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

b. The Trust Liability Calculation

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

2. Claims Pricing

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

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

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

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

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

Any positive or negative differences in estimated or average pricing are accounted for through variance accounts maintained by the Host Blue and are incorporated into future claim prices. As a result, the amounts charged to the Trust will be adjusted in a following year, as necessary, to account for over- or underestimation of the past years' prices. The Host Blue will not receive compensation from how the estimated price or average price methods, described above, are calculated. Because all amounts paid are final, neither positive variance account amounts (funds available to be paid in the following year), nor negative variance amounts (the funds needed to be received in the following year), are due to or from the Trust. If the Trust terminate, you will not receive a refund or charge from the variance account.

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

3. BlueCard Program Fees and Compensation

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

B. Return of Overpayments

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

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

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

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

D. Nonparticipating Providers Outside BCI Service Area

Please refer to the Additional Amount of Payment Provisions section in this Plan.

E. Blue Cross Blue Shield Global Core

1. General Information

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

- **Inpatient Services**

  In most cases, if Participants contact the BCBS Global Core Service Center for assistance, hospitals will not require Participants to pay for covered Inpatient services, except for their deductibles, cost-sharing, etc.. In such cases, the hospital will submit Participant claims to the BCBS Global Core service center to initiate claims processing. However, if the Participant paid in full at the time of service, the Participant must submit a claim to obtain reimbursement for Covered Services. **Participants must contact Blue Cross of Idaho to obtain precertification for non-emergency Inpatient services.**

- **Outpatient Services**

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

- **Submitting a BCBS Global Core Claim**

  When Participants pay for Covered Services outside the BlueCard service area, they must submit a claim to obtain reimbursement. For institutional and professional claims, Participants should complete a BCBS Global Core claim form and send the claim form with the Provider's itemized bill(s) to the BCBS Global Core service center address on the form to initiate claims processing. The claim form is available from Blue Cross of Idaho, the BCBS Global Core service center, or online at www.bcbsglobalcore.com. If Participants need assistance with their claim submissions, they should call the BCBS Global Core service center at 1 .800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.

2. BCBS Global Core-Related Fees

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

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

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

XX. Individual Benefits Management

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

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

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

XXI. Coverage and Benefits Determination

BCI is vested with authority and discretion to determine eligibility for coverage and whether a claim for benefits is covered under the terms of this Plan, based on all the terms and provisions set forth in this Plan, and also to determine the amount of benefits owed on claims which are covered.

XXII. Health Care Providers Outside the United States

The benefits available under this Plan are also available to Participants traveling or living outside the United States. The Inpatient Notification and Prior Authorization requirements will apply. If the Provider is a Contracting Provider with BlueCard, the Contracting Provider will submit claims for reimbursement on behalf of the Participant. Reimbursement for Covered Services will be made directly to the Contracting Provider. If the Health Care Provider does not participate with BlueCard, the Participant will be responsible for payment of services and submitting a claim for reimbursement to BCI. BCI will require the original claim along with an English translation. It is the Participant's responsibility to provide this information.

BCI will reimburse covered Prescription Drugs purchased outside the United States by Participants who live outside the United States where no suitable alternative exists. Reimbursement will also be made in instances where Participants are traveling and new drug therapy is initiated for acute conditions or where emergency replacement of drugs originally prescribed and purchased in the United States is necessary. The reimbursable supply of drugs in travel situations will be limited to an amount necessary to assure continuation of therapy during the travel period and for a reasonable period thereafter.

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

RIGHTS OF PLAN PARTICIPANTS

As a participant in the Idaho AGC Self-Funded Benefit Trust Benefit Plan, you are entitled to certain rights under federal law.

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

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

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

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

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

Idaho AGC Self-Funded Benefit Trust

GENERAL BENEFIT PLAN SUMMARY

Selected Benefits and Percentages

Contract Effective Date: 01/01/2019

Group Number: 1680

Deductible:	**PPO**	**Premier**
Per Person	$50	$50
Per Family	$150	$150

Excluding Diagnostic and Preventive services per benefit year.

Maximum Benefit:	$1,000	$1,000

Per eligible person per benefit year.

Benefit Year: 01/01/2019 - 12/31/2019

	PPO	**Premier**
Preventive & Diagnostic Services: *Examinations, x-rays, teeth cleaning*	100%	80%
Basic Services: *Fillings, root canals, extractions, minor oral surgery*	80%	80%
Major Services: *Crowns, onlays, bridges, dentures*	50%	50%
Implants:	50%	50%

Value-Added Orthodontic Discount Program

Delta Dental of Idaho subscribers and their eligible dependents can receive a discounted fee for adult and child orthodontia treatment if they obtain services from a Delta Dental Discount Program orthodontist in Idaho. Please see your employer for additional information. This value-added service is not insurance.

Additional Benefits / Limitations

Class I Preventive and Diagnostic Services
Examinations once every 6 months; Cleanings once every 6 months (restricts against periodontal maintenance within the same time period); Fluoride once every 12 months for dependent children under age 19; Sealants once per tooth every 3 years for dependent children under 19; Full mouth series or panoramic x-rays once every 5 years; Bitewing x-rays once every 12 months; Space maintainers under age 14 once a lifetime per permanent tooth.

Class II Basic Services
Periodontal maintenance once every 6 months (restricts against basic cleaning within the same time period); Full mouth debridement (4355) is a benefit if no cleanings within 12 months of the service date (an additional cleaning is allowed within 60 days of the full mouth debridement); Scaling and root planing (4341, 4342) covered once every 24 months per quadrant; Root Canals, Extractions, Periodontics; Fillings restricted to same tooth/surface once every 24 months; Posterior fillings are paid as composites; Composite fillings are not downgraded to amalgam; Nitrous oxide is not covered.

Dependents
Eligible children must be under age 26.

Class III Major Restorative Services
Crowns, Build-ups, stainless steel crowns, onlays, or bridges on same tooth once every 7 years; For dependent children under age 16, benefits are limited to plastic or stainless steel crowns on same tooth; Prosthetic services pay on the prep date; Occlusal guards are covered for bruxism only once in 24 months; Missing tooth clause does not apply; TMJ is not a covered benefit; Partials, or dentures 1 time per arch every 7 years, eligible for partials at age 16. ***Late enrollee waiting period is 24 months.***

Implants:
Implants are a covered benefit per tooth with a maximum lifetime benefit of $900 (including crown) applied to the annual individual maximum benefit.

Value-Added Orthodontic Discount Program
Delta Dental of Idaho subscribers and their eligible dependents can receive a discounted fee for adult and child orthodontia treatment if they obtain services from a Delta Dental Discount Program orthodontist in Idaho. Please see your employer for additional information. This value-added service is not insurance.

This is only a general summary of benefits. It provides a brief description about the important features of this policy and does not constitute a contract or guarantee of payment. Full terms and conditions are set forth in the policy provisions. If you have any questions about your benefit plan's coverage detail and benefits or would like to submit a predetermination before services are performed, please call one of our friendly Delta Dental customer service advisors at (208) 489-3580. You may also log onto our website, deltadentalid.com, for benefit and eligibility information or up-to-date claim status. If you have a fax machine, you may access your eligibility and claim information by calling Delta Dental's ProFax number at (208) 489-3545.

DELTA DENTAL OF IDAHO
555 E PARKCENTER BLVD
Boise, ID 83706-6503

Eligibility: (208) 489-3582
Claims Questions: (208) 489-3580

Fax: (208) 344-4649

Dental Benefits

Below is a general list of services your dental care program covers when performed by a dental provider (licensed dentist, certified denturist or registered hygienist). These services are covered only when determined to be necessary and customary by the standards of generally accepted dental practice for the prevention or treatment of oral disease or for accidental injury (accidental injury coverage is secondary to medical). A panel of dentists shall determine these standards.

Covered dental services are outlined in three "classes" that start with preventive care and advance into specialized dental procedures. Covered dental services include coverage for dentally necessary care and treatment of a Congenital Anomaly for newborn and newly adopted children.

Deductible
Before a Participant shall qualify for the benefits, each Participant must have incurred, subsequent to the Effective Date of coverage, the deductible amount of $50 each *Plan Year*. Each family member must meet the deductible; however, no family shall be obligated to meet more than three (3) separate deductibles each *Plan Year*.

Percentage of Fees Paid
Participating PPO Dentist fees will be paid at one hundred percent (100%) of the accepted fee for Class I services, eighty percent (80%) of the accepted fee for Class II services, and fifty percent (50%) of the accepted fee for Class III services.

Participating Premier Dentist fees will be paid at eighty (80%) of the accepted fee for Class I services, eighty percent (80%) of the accepted fee for Class II services, and fifty percent (50%) of the accepted fee for Class III services.

Services of a Nonparticipating Dentist: In the event covered services are provided by a Nonparticipating Dentist, the enrollee will be reimbursed at the appropriate percentage (outlined above) of the accepted fee for services listed below. The member is responsible for payment of any fees greater than the accepted fee for the covered service.

Maximum Benefits
Benefits provided shall not exceed $1,000 per enrollee each *Plan Year*.

CLASS I: (not subject to the deductible) – Preventive services consisting of:

1) Oral examination (limited to once in a six [6] month period).
2) Full mouth x-rays or panorex x-ray (limited to once every five [5] years).
3) Dental x-rays (bitewing x-rays limited to once each twelve [12] months).
4) Prophylaxis, including periodontal prophylaxis (limited to once in a six [6] month period).
5) Topical application of fluoride for enrollees under nineteen (19) years of age (limited to once each twelve [12] consecutive calendar months).
6) Space maintainers, including adjustments made within six (6) months of installation (limited to enrollees age eighteen [18] and under).
7) Topical application of sealants for enrollees up to nineteen (19) years of age (limited to once in any three [3] year period).
8) Topical Application of sealants for adults allowed twice within 12 months after periodontal surgery to protect roots from caries.

CLASS II - Basic services consisting of:

1) Palliative emergency treatment and emergency oral examination. See Class I for examination benefits.

2) Biopsies of the oral tissue.
3) Pulp vitality tests.
4) If the enrollee elects to have another more costly restorative material, covered dental services shall be limited to the cost of the filling *composite*. A restoration shall be considered a covered dental service once in a two (2) year period on the same surface of a tooth.
5) Endodontics, including pulpotomy, root canal treatment, Apicoectomy, and Hemisection.
6) Oral Surgical services limited to:
    a) Simple extractions.
    b) Surgical removal of teeth and maxillary or mandibular intrabony cysts, procedures performed for the preparation of the mouth for dentures. The allowance for an oral surgery includes a treatment plan, local anesthesia and postoperative care.
    c) General anesthesia and I.V. sedation when it is necessary for multiple partial, or complete boney extractions or for complex oral surgery due to the existence of a concurrent condition.
    d) Mucogingivoplastic Surgery.
    e) Management of acute periodontal infection and oral lesions. Prophylaxis for periodontal maintenance shall be provided once each six (6) months, subject to review for document guidelines.

7) Complex periodontal services, including gingival curettage, gingivectomy, osseous surgery, flap entry and closure, and mucogingivoplastic surgery. Periodontal surgery includes the treatment plan, local anesthesia,

   pre-operative and post-operative care for a period of three (3) months. Periodontal surgical services are covered once, per quadrant, with pocket of 5 mm or more, in any *three (3)* year period.
8) Benefits for inlays provided at the same total benefit as a composite filling for posterior (back) teeth and as composite filling for anterior (front) and bicuspid teeth, once every 24 months.

CLASS III - Major services consisting of:

1) Initial installation of dentures or bridgework to replace one or more natural teeth which have been extracted.
2) Replacement of existing dentures or bridgework, provided that the existing denture or bridgework was installed at least seven (7) years prior to its replacement and cannot be made serviceable.
3) Repairs to existing dentures or bridgework (limited to once each twenty-four (24) consecutive calendar months).
4) Denturity services limited to:
    a) The making, fitting, constructing, altering, reproducing, or repairing of a full upper or lower removable prosthetic denture, the repairing of a removable partial upper or lower prosthetic denture, the furnishing or supplying of such a denture directly to a person or advising the use of any such denture.
    b) The taking or making, or the giving of advice, assistance or facilities respecting the taking or making of any impression, bite, cast or design preparatory to, or for the purpose of making, constructing, fitting, furnishing, supplying, altering, repairing or reproducing any such full upper or lower removable prosthetic denture.
    c) Within the context of this provision, all work except cast frame work must be performed on the denturist's premise.
5) Fixed bridge repairs, repair of removable dentures, re-cementing of crowns, and/or bridges.
6) Denture re-lining (limited to once each two [2] years).
7) Crowns, limited to once each seven [7] years. Repair of crowns are limited to once every 24 months.

8) Veneer to replace a tooth structure that cannot be replaced by another restoration in those situations which would qualify for placement of a full crown, subject to Delta Dental’s approval.
9) Onlays according to the same pricing and necessity guidelines that apply to crowns, subject to Delta Dental’s approval.
10) Repair to existing dentures, removable dentures, bridgework, inlays and/or onlays.

Value –Added Orthodontic Discount Program

Delta Dental of Idaho Participants and their eligible dependents can receive a discounted fee for adult and child orthodontic treatment if they obtain services from a Delta Dental Discount Program orthodontist in Idaho. Please see your employer for additional information. **This value-added service is not insurance.**

Dental Exclusions and Limitations

No benefits shall be provided in connection with the following:

1) Dental services with respect to congenital malformations or primarily for cosmetic or aesthetic purposes, except for newborn and adopted children.
2) Nitrous oxide.
3) Dental services for which the enrollee would have no legal obligation to pay in the absence of this or any similar coverage.
4) Dental care or treatment not specifically listed as eligible.
5) Charges for replacement of lost or stolen items.
6) Hospitalization in connection with covered dental services.
7) Dental work covered under the Workers' Compensation Law.
8) Charges which exceed the accepted fee as determined by Delta Dental.
9) Orthodontic treatment, including correction of malocclusion.
10) Diagnostic photographs, diagnostic casts, and study models.
11) Duplicate x-rays.
12) Oral hygiene instruction.
13) Recontouring restorations.
14) Replacements of space maintainers.
15) Temporary dentures.
16) Replacement of crowns and gold cast restorations, (including inlays and onlays) less than seven (7) years old.
17) Any condition, disease, ailment, Injury, or diagnostic service to the extent that benefits are provided under Medicare.
18) Charges for which benefits or services are provided for a member under any group, Blue Shield/Blue Cross or other insurance or prepayment plan arranged through an employer, union, trustee or association.
19) Occlusal equilibration and/or treatment for temporomandibular joint (TMJ) disorders.
20) Experimental dental procedures.
21) Payment for dental services incurred prior to the date the enrollee became eligible for such services under the plan. An expense is incurred when:
    a. the impression is taken - in the case of dentures, or fixed bridgework;
    b. preparation of the tooth is begun - in the case of crown work; or
    c. work on the tooth is begun - in the case of root canal therapy.
22) In the event an enrollee transfers from the care of one dentist to that of another dentist during the course of treatment, or if more than one dentist renders services for a dental procedure, Delta Dental shall be liable for not more than the amount it would have been liable for had but one dentist rendered the service. In all cases in which there are optional techniques of treatment carrying different fees, Delta Dental shall be liable hereunder only for the treatment carrying the lesser fee.

CLAIMS AND PAYMENT FOR SERVICES

1) Submission of Claim: After the last day on which services are rendered, a report of services rendered shall be submitted to Delta Dental.

2) Payment for Eligible Services:

    a) Benefits for covered services provided by a Participating Dentist shall be made by Delta Dental directly to such Participating Dentist.
    b) Benefits for covered services provided by a Nonparticipating Dentist may be made by Delta Dental directly to the enrollee.

LATE CLAIMS

No payment will be made on any claims submitted to Delta Dental more than twelve (12) months after the last day on which the services were rendered, unless it shall be shown to the satisfaction of Delta Dental that there was unusual and justifiable cause of such late submission.

Your VSP Vision Benefits Summary

IDAHO AGC SELF-FUNDED BENEFIT TRUST and VSP provide you with an affordable eye care plan.

VSP Provider Network: VSP Choice

Benefit	Description	Copay	Frequency
Your Coverage with a VSP Provider			
WellVision Exam	• Focuses on your eyes and overall wellness • Please check if your Costco optometrist is a participating retail provider	$10	Every 12 months
Prescription Glasses		$20	See frame and lenses
Frame	• $150 allowance for a wide selection of frames • $170 allowance for featured frame brands • 20% savings on the amount over your allowance • $80 Costco® frame allowance	Included in Prescription Glasses	Every 24 months
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for dependent children	Included in Prescription Glasses	Every 12 months
Lens Enhancements	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 20-25% on other lens enhancements	$55 $95 - $105 $150 - $175	Every 12 months
Contacts (instead of glasses)	• $150 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation)	Up to $60	Every 12 months
Extra Savings	**Glasses and Sunglasses** • Extra $20 to spend on featured frame brands. Go to vsp.com/specialoffers for details. • 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam.		
	Retinal Screening • No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam		
	Laser Vision Correction • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities		

Your Coverage with Out-of-Network Providers

Get the most out of your benefits and greater savings with a VSP network doctor. Your coverage with out-of-network providers will be less or you'll receive a lower level of benefits. Visit **vsp.com** for plan details.

Exam ..... up to $45	Lined Bifocal Lenses ..... up to $50	Progressive Lenses ..... up to $50
Frame ..... up to $70	Lined Trifocal Lenses ..... up to $65	Contacts ..... up to $105
Single Vision Lenses ..... up to $30		

Coverage with a participating retail chain may be different. Once your benefit is effective, visit vsp.com for details. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location.

Contact us. **800.877.7195** | **vsp.com**

1. Brands/Promotion subject to change.
2. Savings based on network doctor's retail price and vary by plan and purchase selection; average savings determined after benefits are applied. Available only through VSP network doctors to VSP members with applicable plan benefits. Ask your VSP network doctor for details.

3. Blueocean Market Intelligence National Vision Plan Member Research, 2014

VSP VISION CARE, INC.
SCHEDULE OF BENEFITS
VSP Choice Plan

This Schedule lists the vision care services and vision care materials to which Covered Persons of VSP VISION CARE, INC.("VSP") are entitled, subject to any Copayments and other conditions, limitations and/or exclusions stated herein. If Plan Benefits are available for Non-Member Provider services, as indicated by the reimbursement provisions below, vision care services and vision care materials may be received from any licensed optometrist, ophthalmologist, or dispensing optician, whether Member Doctors or Non-Member Providers. This Schedule forms a part of the Plan or Certificate to which it is attached.

Member Doctors are those doctors who have agreed to participate in VSP's Choice Network.

When Plan Benefits are received from Member Doctors, benefits appearing in the first column below are applicable subject to any Copayments as stated below. When Plan Benefits are available and received from Non-Member Providers, the Covered Person is reimbursed for such benefits according to the schedule in the second column below less any applicable Copayments.

COPAYMENT

The benefits described herein are available to each Covered Person subject only to payment of the applicable Copayment by the Covered Person. Copayments are required for Plan Benefits received from Member Doctors and Non-Member Providers. Covered Persons must also follow the proper procedures for obtaining Benefit Authorization.

There shall be a Copayment of $10.00 for the examination payable by the Covered Person to the Member Doctor at the time services are rendered. If materials (lenses and frames) are provided, there shall be an additional $20.00 Copayment payable at the time the materials are ordered. However, the Copayment for materials shall not apply to elective contact lenses.

PLAN BENEFITS

	MEMBER DOCTOR BENEFIT	NON-MEMBER PROVIDER BENEFIT
VISION CARE SERVICES		
Eye Examination	Covered in Full*	Up to $ 45.00*

Complete initial vision analysis which includes an appropriate examination of visual functions, including the prescription of corrective eyewear where indicated.

Subsequent regular eye examinations every 12 months.

*Less any applicable Copayment.

VISION CARE MATERIALS

	MEMBER DOCTOR BENEFIT	NON-MEMBER PROVIDER BENEFIT
Lenses		
Single Vision	Covered in full*	Up to $ 30.00*
Bifocal	Covered in full*	Up to $ 50.00*
Trifocal	Covered in full*	Up to $ 65.00*
Lenticular	Covered in full*	Up to $ 100.00*

Available once every 12 months.

Frames	Covered up to Plan Allowance*	Up to $ 70.00*

Available once every 24 months.
*Less any applicable Copayment.

Client charge shall be determined by the then applicable wholesale/retail equivalent conversion factor.

Lenses and frames include such professional services as are necessary, which shall include:

- Prescribing and ordering proper lenses;
- Assisting in the selection of frames;
- Verifying the accuracy of the finished lenses;
- Proper fitting and adjustment of frames;
- Subsequent adjustments to frames to maintain comfort and efficiency;
- Progress or follow-up work as necessary.

CONTACT LENSES

Contact lenses are available once every 12 months in lieu of all other lens and frame benefits available herein. When contact lenses are obtained, the Covered Person shall not be eligible for lenses and frames again for 12 months.

Necessary-

Necessary Contact Lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's Member Doctor or Non-Member Provider. Prior review and approval by VSP are not required for Covered Person to be eligible for Necessary Contact Lenses.

MEMBER DOCTOR BENEFIT	NON-MEMBER PROVIDER BENEFIT
Professional Fees and Materials	Professional Fees and Materials
Covered in full*	Up to $210.00*

Elective -

MEMBER DOCTOR BENEFIT	NON-MEMBER PROVIDER BENEFIT
Elective Contact Lens fitting and evaluation** services are covered in full once every 12 months, after a maximum $60.00 Copayment.	
Materials	Professional Fees and Materials
Up to $150.00	Up to $105.00

*Subject to Copayment

**15% discount applies to Member Doctor's usual and customary professional fees for contact lens evaluation and fitting.

LOW VISION BENEFIT

The Low Vision benefit is available to Covered Persons who have severe visual problems that are not correctable with regular lenses.

	MEMBER DOCTOR BENEFIT	NON-MEMBER PROVIDER BENEFIT
Supplementary Testing	Covered in Full	Up to $125.00

Complete low vision analysis/diagnosis, which includes a comprehensive examination of visual functions, including the prescription of corrective eyewear or vision aids where indicated.

Supplemental Care Aids	75% of Cost	75% of Cost

Subsequent low vision aids.

Copayment for Supplemental Aids: 25% payable by Covered Person.

Benefit Maximum

The maximum benefit available is $1000.00 (excluding Copayment) every two years.

NON-MEMBER PROVIDER BENEFIT

Low Vision benefits secured from a Non-Member Provider are subject to the same time limits and Copayment arrangements as described above for a Member Doctor. The Covered Person should pay the Non-Member Provider his full fee. The Covered Person will be reimbursed in accordance with an amount not to exceed what VSP would pay a Member Doctor in similar circumstances. NOTE: There is no assurance that this amount will be within the 25% Copayment feature.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

Some brands of spectacle frames may be unavailable for purchase as Plan Benefits, or may be subject to additional limitations. Covered Persons may obtain details regarding frame brand availability from their VSP Member Doctor or by calling VSP's Customer Care Division at (800) 877-7195.

PATIENT OPTIONS

This Plan is designed to cover visual needs rather than cosmetic materials. When the Covered Person selects any of the following extras, the Plan will pay the basic cost of the allowed lenses or frames, and the Covered Person will pay the additional costs for the options.

- Optional cosmetic processes.
- Anti-reflective coating.
- Color coating.
- Mirror coating.
- Scratch coating.
- Blended lenses.
- Cosmetic lenses.
- Laminated lenses.
- Oversize lenses.
- Polycarbonate lenses.
- Photochromic lenses, tinted lenses except Pink #1 and Pink #2.
- Progressive multifocal lenses.
- UV (ultraviolet) protected lenses.
- Certain limitations on low vision care.
- A frame that costs more than the Plan allowance.
- Contact lenses (except as noted elsewhere herein).

NOT COVERED

There is no benefit for professional services or materials connected with:

- Orthoptics or vision training and any associated supplemental testing; plano lenses (less than a ± .50 diopter power); or two pair of glasses in lieu of bifocals;

- Replacement of lenses and frames furnished under this Plan which are lost or broken, except at the normal intervals when services are otherwise available;

- Medical or surgical treatment of the eyes;

- Corrective vision treatment of an Experimental Nature;

- Costs for services and/or materials above Plan Benefit allowances;

- Services and/or materials not indicated on this Schedule as covered Plan Benefits.

VSP MAY, AT ITS DISCRETION, WAIVE ANY OF THE PLAN LIMITATIONS IF, IN THE OPINION OF VSP's OPTOMETRIC CONSULTANTS, IT IS NECESSARY FOR THE VISUAL WELFARE OF THE COVERED PERSON.

PLAN BENEFITS
AFFILIATE PROVIDERS

GENERAL

Affiliate Providers are providers of Covered Services and Materials who are not contracted as Member Doctors but who have agreed to bill VSP directly for Plan Benefits provided pursuant to this Schedule. However, some Affiliate Providers may be unable to provide all Plan Benefits included in this Schedule. Covered Person should discuss requested services with their provider or contact VSP Customer Care for details.

COPAYMENT

There shall be a Copayment of $10.00 for the examination payable by the Covered Person at the time services are rendered. If materials (lenses and frames) are provided, there shall be an additional $20.00 Copayment payable at the time the materials are ordered. The Copayment for materials shall not apply to Elective Contact Lenses.

COVERED SERVICES AND MATERIALS

EYE EXAMINATION- Covered in full* once every 12 months**

Comprehensive examination of visual functions and prescription of corrective eyewear.

LENSES - Covered in full* once every 12 months**
Spectacle Lenses (Single, Lined Bifocal, or Lined Trifocal)

FRAMES - Covered up to the Plan allowance* once every 24 months**

CONTACT LENSES

ELECTIVE
Elective Contact Lenses (materials only) are covered up to $150.00 once every 12 months.

Elective Contact Lens fitting and evaluation services are covered in full once every 12 months, after a maximum $60.00 Copayment.

NECESSARY
Necessary Contact Lenses are covered up to $210.00* once every 12 months**

Necessary Contact Lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's Doctor.

Contact Lenses are provided in place of spectacle lens and frame benefits available herein.

*Less any applicable Copayment.
**Beginning with the first date of service.

When contact lenses are obtained, the Covered Person shall not be eligible for lenses and frames again for 12 months.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

1. Exclusions and limitations of benefits described above for Member Doctors shall also apply to services rendered by Affiliate Providers.
2. Services from an Affiliate Provider are in lieu of services from a Member Doctor or a Non-Member Provider.
3. VSP is unable to require Affiliate Providers to adhere to VSP's quality standards.
4. Where Affiliate Providers are located in membership retail environments, Covered Persons may be required to purchase a membership in such entities as a condition of obtaining Plan Benefits.

EXHIBIT B

VSP VISION CARE, INC.
SCHEDULE OF ADVANCE PAYMENT AND ADMINISTRATIVE FEE
VSP Choice Plan

VSP shall be entitled to receive amounts due for each month on behalf of each Enrollee and his/her Eligible Dependents, if any in the amounts specified below:

ADVANCE PAYMENT: $0.00
ADMINISTRATIVE FEE:

$	.69	per month for each eligible Enrollee without dependents.
$	1.00	per month for each eligible Enrollee with an eligible spouse.
$	1.81	per month for each eligible Enrollee with eligible child(ren).

NOTICE: The amount due under this Plan is subject to change upon renewal (after the end of the Plan Term or any subsequent Plan Term) or upon change of the Schedule of Benefits or a material change in any other terms or conditions of the Plan.

Lincoln Financial Group®

Group Short-Term Disability Insurance

SUMMARY OF BENEFITS

Sponsored by: **Idaho AGC Benefit Plan Trust**

All Full-Time Employees Enrolled in The Idaho AGC Sponsored Medical Plan

Short-term disability is intended to protect your income for a short duration in case you become ill or injured.

STD Benefit			
	Weekly Benefit	**Elimination Period**	**Maximum Duration**
	100% of weekly salary up to $125 per week	Benefits begin on: Accident: 15th day Illness: 15th day	13 weeks
Integration of Benefits	The benefits from this policy will be reduced by benefits you receive from state disability or worker's compensation programs.		
Waiver of Premium	You will not be required to pay premium during any time of approved total or partial disability.		
Additional Benefits			
	Rehab Assistance - 5% **Survivor Income - 3 Weeks** **C-Section Benefit - 8 weeks** **See your Schedule of Benefits on your Certificate for more information**		
Enrolling for Coverage			
Eligibility:	All employees in an eligible class.		

Understanding Your Benefits	
Total Disability	Due to an injury or illness, you are unable to perform each of the main duties of your regular occupation.
Partial Disability	Due to an injury or illness, you are unable to perform one or more of the main duties of your regular occupation on a full-time basis. Partial Disability benefits may be payable if you are earning at least 20% of the income you earned prior to becoming disabled, but not more than 99%. Partial disability benefits allow you to work and earn income from your employer as well as continue to receive benefits, which may enable you to receive 100% of your income during your time of disability.
Total Disability	Due to an injury or illness, you are unable to perform with reasonable continuity the substantial and material acts necessary in your own occupation.
Partial Disability	Due to an injury or illness, you are unable to earn 80% or more of your income and you are not Totally Disabled. The Partial Disability benefits allow you to earn up to 100% of your income from your partial earnings, other sources of income and your disability benefit.
Continuation of Disability	If you return to work full-time but become disabled from the same disability within 2 weeks of returning to work, you will begin receiving benefits again immediately.
Benefit Exclusions	You will not receive benefits in the following circumstances: • Your disability is the result of a self-inflicted injury. • You are not under the regular care of a doctor when requesting disability benefits. • Your disability is covered under a worker's compensation plan and/or is due to a job-related sickness or injury.
Benefit Reductions	Your benefits may be reduced if you are receiving benefits from any of the following sources: • Any governmental retirement system earned as a result of working for the current policyholder; • Any disability or retirement benefit received under a retirement plan; • Any Social Security, or similar plan or act, benefits; • Earnings the insured earns or receives from any form of employment; • Disability income benefits received under state disability benefit laws.
Rehabilitation Assistance Benefit	Employees who participate in an approved rehabilitation program are eligible to receive an additional percent of benefit. Additionally, approved program costs may be reimbursed.
Survivor Income	A benefit may be paid to your survivor for additional months if you should die while you were eligible to receive benefits under this policy.
Coverage Termination	This coverage will terminate when you terminate employment with this policyholder, or at your retirement.

For assistance or additional information Contact Lincoln Financial Group at	
(800) 423-2765; reference ID: **IDASSOCGC**	www.LincolnFinancial.com

NOTE: This is not intended as a complete description of the insurance coverage offered. Controlling provisions are provided in the policy, and this summary does not modify those provisions or the insurance in any way. This is not a binding contract. A certificate of coverage will be made available to you that describes the benefits in greater detail. Should there be a difference between this summary and the policy, the policy will govern.

Group Insurance products are issued by The Lincoln National Life Insurance Company (Ft. Wayne, IN), **which is not licensed and does not solicit business in New York**. In New York, group insurance products are issued by Lincoln Life & Annuity Company of New York (Syracuse, NY). Both are Lincoln Financial Group companies. Product availability and/or features may vary by state. Lincoln Financial Group is the marketing name for Lincoln National Corporation and its affiliates. **Each affiliate is solely responsible for its own financial and contractual obligations.**

Lincoln Financial Group®

Group Term Life Insurance
Life and AD&D

SUMMARY OF BENEFITS

Sponsored by: Idaho AGC Benefit Plan Trust

All Full-Time Employees Participating in The Idaho AGC Sponsored Medical Plan

Coverage	Benefit Amount Employee	Benefit Amount Spouse and Dependents
Life	$25,000	Spouse: $5,000 Child: 14 days but less than 26 years (unmarried): 5,000
Guarantee Issue	$25,000	
AD&D	Will Equal the Life Benefit	N/A
Benefit Reduction	**Employee**	**Spouse**
Benefits will reduce:	35% at age 70; An additional 15% of original amount at age 75; An additional 20% of original amount at age 80; Benefits terminate at retirement	Benefits terminate at Spouse age 70
Additional Benefits		
See Understanding Your Benefits Page:	Accelerated Death Benefit Seat Belt, Airbag, and Common Carrier Conversion Accident Plus	
Enrolling for Coverage	**Employee**	**Spouse or Dependent**
Eligibility:	All employees in an eligible class.	Effective date of coverage will be delayed if Spouse or dependent is in a period of limited activity on policy issue date.

(Please see other side)

Understanding Your Benefits	
Accelerated Death Benefit	Accelerated Death Benefit provides an option to be paid a portion of your life insurance benefit when diagnosed as terminally ill (as defined in the policy). The death benefit will be reduced by the amount withdrawn. To qualify, you must be covered under this policy for the amount of time defined by the policy.
AD&D	Accidental Death and Dismemberment (AD&D) insurance provides specified benefits for a covered accidental bodily injury that directly causes death or dismemberment (e.g., the loss of a hand, foot, or eye), subject to policy limitations.
Conversion	If you terminate your employment or become ineligible for this coverage, you have the option to convert all or part of the amount of coverage in force to an individual life policy on the date of termination without Evidence of Insurability. Conversion election normally must be made within 31 days of your date of termination.
Guarantee Issue	For timely entrants enrolled within 31 days of becoming eligible, the Guarantee Issue amount is available without providing Evidence of Insurability. Evidence of Insurability will be required for any amounts above this, for late enrollees or increases in insurance, and it will be provided at your own expense.
Seat Belt, Airbag, & Common Carrier	If you die as a result of a covered auto accident while wearing a seat belt or in a vehicle equipped with an airbag, additional benefits are payable up to $10,000 or 10% of the principal sum, whichever is less. If loss occurs due to an accident while riding as a passenger in a common carrier, benefits will be double the amount that would otherwise apply as outlined in the certificate.
Limited Activity	A period when a Spouse or dependent is confined in a health care facility; or, whether confined or not, is unable to perform the regular and usual activities of a healthy person of the same age and sex.
Accident Plus	If loss occurs due to an accident, you may also receive the following Accident Plus benefits: Coma, Plegia, Repatriation, Education, Spouse Training, & Child Care. Refer to your certificate for more details.
Term Life	A death benefit is paid to the designated beneficiary upon the death of the insured. Coverage is provided for the time period that you are eligible and premium is paid. There is no cash value associated with this product.
Additional Benefits	
***LifeKeys*SM**	Online will & testament preparation service, identity theft resources and beneficiary assistance support for all employees and eligible dependents covered under the Group Term Life and/or AD&D policy.
***TravelConnect*SM**	Travel assistance services for employees and eligible dependents traveling more than 100 miles from home.

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Life is a challenge. We provide support to see you through it.

Welcome to the Idaho AGC Health Plan EAP Program. You have up to 3 sessions per incident per benefit year.

Your EAP (Employee Assistance Program) is a benefit provided by your employer to help you successfully address work and personal problems that impact your life.

BPA Health, the administrator of your EAP, connects you to face-to-face counseling professionals, web-based tools and other resources that will help you sort out work, personal or family issues.

- ***Personal:*** Stress, anxiety, depression, grief, drug or alcohol use
- ***Relationship:*** Marriage, separation or divorce, family, parenting, domestic abuse
- ***Work:*** Anger management, job change, co-worker conflicts, ethics
- ***Legal & financial:*** Wills, budgeting, financial planning, divorce, identity theft protection and recovery

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Accessing your EAP is easy, confidential and no cost to you.

Services are provided at no cost to eligible employee and family and are strictly confidential.
To access services call **1-800-726-0003**.
Crisis counselors are available **24 hours a day, 7 days a week.**

BPAHealth.com

Connect. Improve. Achieve.

Employee Assistance Program (EAP)

Secure Video Counseling

Video Counseling – a new way to use your EAP Sessions!

What is it?

As of January 1, 2019, BPA Health will be offering you the option to see your EAP counseling professional either in person, or via secure video.

Why Use Secure Video?

- **Ease** – use on your smartphone or laptop with a camera
- **Convenience** – keep appointments while traveling, or fit them in during the day, without having to travel to an office; or use both in-person and video as needed based on your schedule
- **Access** – to providers in your home State regardless of where you live

Are there tips for successfully using video sessions?

Make sure to find a quiet space that is private; wear headphones or earbuds; reduce distractions; and close out other programs or apps.

How to access secure video counseling –

Easy as 1, 2, 3!

#1 – Video Counseling:
As of January 1, 2019

Please note that our website will be updated as of this date to reflect video counseling as an option.

#2 - Visit and Choose:
bpahealth.com/eap-home

Search for video counselors

#3 - Call BPA Health:
Call 1-800-726-0003 to request an authorization prior to seeing a Provider

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Note:
All approved Providers use HIPAA compliant systems to protect your privacy

Questions?
Log in to the website, or call us, as listed above.

"...the video counseling modality is just as powerful as in-person counseling..."

Edward R Jones, Ph.D.

BPA Health
380 Parkcenter Blvd., #300
Boise, ID 83706 USA

This Summary Plan Description prepared by

Idaho AGC HEALTH PLAN