IDAHO AGC HEALTH PLAN

Employee Benefit Plan

Designed Exclusively for Idaho AGC members and their employees

$2,750 Deductible Connect Care
Mountain View Network

Effective Date: January 1, 2026

Idaho AGC Self-Funded Benefit Trust
Sponsored By: Idaho Branch, Inc. Associated General Contractors of America Inc.

**Not all plans include the Dental and Vision Bundle. Check with your employer*
This is a self-funded plan and is not insurance and does not participate in the Idaho Life & Health Guaranty Association

Trust: Idaho AGC Self-Funded Benefit Trust
Plan Sponsor: Idaho Branch, Inc. Associated General Contractors of America, Inc.

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.

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

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, 2026 and ending December 31, 2026 This plan provides coverage for more than one class of employees

Legal Name of the Plan:	Idaho AGC Self-Funded Benefit Trust DBA: Idaho AGC Health Plan
Plan Number:	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, Voluntary Accident, Voluntary Critical Illness 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: Vimly Benefit Solutions 12121 Harbour Reach Drive, Suite 105 Mukilteo WA 98275 (833) 468-4659 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

Life, AD&D, and Short-Term disability, Accident and Criticial Illness benefits are provided through a service contract with: Equitable
1345 Avenue of the Americas
New NY 10105
Phone: (866) 274-9887

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

Adam Warr
Buss Mechanical Services, Inc.
4473 Henry St.
Boise, ID 83709
P: (208) 562-0600
Adam@bussmechanical.com

Kevin Brown
Guy Nielson Co., Industrial Division, Inc.
474 Taft Avenue
Pocatello, ID 83201
P: (208) 233-2693
kbrown@guynielson.com

Susan Whipps
Guho Corp.
391 W State Stree, Suite 6
Eagle, ID 83616
P: (208) 939-8850
susan@guhocorp.com

Heidi Lockner
Advanced Sign, LLC
2835 E Lanark Street, #100
Meridan, ID 83642
P: (208) 345-8682
heidi@advancedsign.com

Waylin Lewis
Lewis Corporation
15136 W Hunziker Road
Pocatello, ID 83202
P: (208) 238-1202
waylin@lcorp.com

Jill Bell
Franz Witte Landscaping Contracting., Inc
20005 11th Ave N
Nampa ID 83687
P: (208) 853-0808
Jill.b@franzwitte.com

Joey Gibson
YMC, Inc.
2975 E Lanark Street
Meridian, ID 83642
P: (208) 888-1727
jgibson@ymcinc.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
Voluntary Accident
Voluntary Critical Illness

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.

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.

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). I□□□□ □ □□ld ll□e □ □re in□□r□ ati□n □n □ aternit□ □ene□its, call □□□r □lan ad□ instrati□n □□□ce□

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:

- All sta□es □□reconstruction of the breast on which the mastectomy was performed;
- 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 cost-sharing 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.

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.

The 'No Surprises' Rules

The "No Surprises" rules protect you from surprise medical bills in situations where you can't easily choose a provider who's in your health plan network. This is especially common in an emergency situation, when you may get care from out-of-network providers. Out-of-network providers or emergency facilities may ask you to sign a notice and consent form before providing certain services after you're no longer in need of emergency care. These are called "post-stabilization services." You shouldn't get this notice and consent form if you're getting emergency services other than post-stabilization services. You may also be asked to sign a notice and consent form if you schedule certain non-emergency services with an out-of-network provider at an in-network hospital or ambulatory surgical center.

The notice and consent form informs you about your protections from unexpected medical bills, gives you the option to give up those protections and pay more for out-of-network care, and provides an estimate of what your out-of-network care might cost. You aren't required to sign the form and shouldn't sign the form if you didn't have a choice of health care provider or facility before scheduling care. If you don't sign, you may have to reschedule your care with a provider or facility in your health plan's network.

This applies to you if you're a participant, beneficiary, enrollee, or covered individual in a group health plan or group or individual health insurance coverage, including a Federal Employees Health Benefits (FEHB) plan.

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

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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; or
- 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 Human Resources.

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.

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.

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, Medicare, Medicaid, Children's Health Insurance Program (CHIP), 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.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

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

Name of Entity:	Idaho AGC Health Plan
Address:	1649 W Shoreline Drive Suite 100 Boise, Idaho 83702
Phone Number:	208-344-9755

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

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 pre-authorizations).

Health care operations includes but is not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, contribution 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 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 cost-sharing 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:

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:

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 cost-sharing 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 cost-sharing 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 July 31, 2025. Contact your State for more information on eligibility—

ALABAMA – Medicaid
Website: http://myalhipp.com/ | Phone: 1-855-692-5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program | Website: http://myakhipp.com/ | Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com | Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid
Website: http://myarhipp.com/ | Phone: 1-855-MyARHIPP (855-692-7447)
CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 | Fax: 916-440-5676 | Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943 | State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991 | State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ | HIBI Customer Service: 1-855-692-6442
FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra | Phone: 678-564-1162, press 2

INDIANA – Medicaid
Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ | http://www.in.gov/fssa/dfr/ | Family and Social Services Administration Phone: (800) 403-0864 | Member Services Phone: (800) 457-4584
IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: Iowa Medicaid | Health & Human Services | Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services | Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562
KANSAS – Medicaid
Website: https://www.kancare.ks.gov/ | Phone: 1-800-792-4884 | HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx | Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov | Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms
LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en _US Phone: 1-800-442-6003 | TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 800-977-6740 | TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa | Phone: 1-800-862-4840 | TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid
Website: https://mn.gov/dhs/health-care-coverage/ | Phone: 1-800-657-3672
MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm | Phone: 573-751-2005
MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 | email: HHSHIPPProgram@mt.gov
NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 | Lincoln: 402-473-7000 | Omaha: 402-595-1178
NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov | Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 | Toll-free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ | Phone: 800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 | CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)
NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/ | Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/ | Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: https://www.hhs.nd.gov/healthcare | Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org | Phone: 1-888-365-3742
OREGON – Medicaid and CHIP
Website: http://healthcare.oregon.gov/Pages/index.aspx | Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html | Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) | CHIP Phone: 1-800-986-KIDS (5437)
RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/ | Phone: 1-855-697-4347 or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov | Phone: 1-888-549-0820
SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov | Phone: 1-888-828-0059
TEXAS – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493
UTAH – Medicaid and CHIP
Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov | Phone: 1-888-222-2542 | Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select or https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/ | Phone: 1-800-562-3022
WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/ or http://mywvhipp.com/ Medicaid Phone: 304-558-1700 | CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm | Phone: 1-800-362-3002
WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ | Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2025, 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

Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

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 in your geographic area.

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

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the 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 is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[1,2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.

[2] An employer-sponsored or other employment-based 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. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact

_____

_____.

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.

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

Plan Name: Idaho AGC Self-Funded Benefit Trust Plan

Trust: Idaho AGC Self-Funded Benefit Trust

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

Contract Administrator: Blue Cross of Idaho Health Service, Inc.

Benefit Trust Plan
ASC Mountain View Network East Connected Care $2,750 Deductible

Effective January 1, 2026 – December 31, 2026

This is a self-funded plan and is not an insurance policy and the Idaho AGC Self-Funded Benefit Trust does not participate in the Idaho Life and Health Guaranty Association.

Blue Cross of Idaho

BENEFITS OUTLINE

This Benefit Trust Plan constitutes a part of your benefits guide, benefits booklet, summary plan description, or other similar governing plan document (as the case may be) that provides a summary of the Plan. To the extent there is any conflict between such governing Plan documents of the Trust and this Benefit Trust Plan, this Benefit Trust Plan shall be the governing document upon which the Contract Administrator shall administer claims. Notwithstanding any provision in this document to the contrary, if the resolution of a benefit claim is tied to an individual's eligibility for coverage under the Plan, such eligibility determination shall be resolved by the Plan Sponsor.

IMPORTANT INFORMATION ABOUT THIS OUTLINE:
This Benefits Outline describes the benefits in general terms. It is important to read the Benefit Trust 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 this document 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 document references to Blue Cross of Idaho (BCI) are referring to the Contract Administrator. For Covered Services under the terms of the 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. Participants should check with the Contract Administrator 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.

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, the Prior Authorization Section and the Attachment A for specific details.

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 the Contract Administrator 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 or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, please visit our Website 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.

PRIMARY CARE PROVIDER NOTICE:
The Contract Administrator currently requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, the Contract Administrator designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your insurance agent or our Customer Service Department at (208) 286-3439 or (866) 283-6354. You can also search the Contract Administrator's online directly located at the Contract Administrator's Website, www.bcidaho.com, under "Find a Doctor", for names and locations of PCP's.

For children, you may designate a pediatrician as the primary care provider.

PRIMARY CARE PHYSICIAN (PCP)

The Contract Administrator requires the selection of a specific Primary Care Physician (PCP) for each Participant, to ensure a qualified Provider is aware of the care you are currently receiving and have received in the past. The PCP is there to provide you with necessary care and to ensure you receive the right care at the right time. A PCP includes general/family practice, pediatrics, internal medicine, obstetrics and gynecology physicians. *If you did not select a PCP, the Contract Administrator will assign one for you.*

To select a PCP or to change your PCP, please call the Contract Administrator's Customer Service Department at 1-866-283-6354, or in the Boise area dial (208) 286-3439.

POINT OF SERVICE CONNECTED CARE BENEFITS

It is important for you to understand your Point of Service benefits. A Point of Service plan pays Covered Services at the highest benefit level if you seek care from a Contracting Provider. If you seek care from a Contracting Provider, no referral is necessary. This is referred to as In-Network benefits. The Contract Administrator is a holder of a certificate of authority under Title 41, Chapter 39, Idaho Code, through which Blue Cross of Idaho Health Service, Inc., offers managed care health benefit products.

Contracting Provider—a Provider in the Service Area that has entered into a written agreement with the Contract Administrator regarding payment for Covered Services rendered to a Participant under this Mountain View Network East Connected Care program.

If you receive care from a Noncontracting Provider, you may receive benefits however the benefit level may be substantially less. This is referred to as Out-of-Network benefits.

The only exception to this rule regarding care provided by Noncontracting Providers, is in the case of Emergency Services or if you seek care from a Noncontracting Provider with the approval of both your PCP and the Contract Administrator.

REFERRALS

Please refer to the Referral Procedures Section listed in the Plan.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an Out-of-Network Provider at an In-Network Hospital or Ambulatory Surgical Center, you are protected from balance billing. In these cases, you shouldn't be chard more than your plan's Copayment, Cost Sharing and/or Deductible.

WHAT IS "BALANCE BILLING" (SOMETIMES CALLED "SURPRISE BILLING")?

When you see a doctor or other health care Provider, you may owe certain Out-of-Pocket costs, like Copayment, Cost Sharing, or Deductible. You may have additional costs or have to pay the entire bill if you see a Provider or visit a health care facility that isn't in your health plan's network.

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

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

YOU ARE PROTECTED FROM BALANCE BILLING FOR:

Emergency services

If you have an Emergency Medical Condition and get emergency services from an Out-of-Network Provider or facility, the most they can bill you is your plan's In-Network cost-sharing amount (such as Copayments, Cost Sharing and Deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an In-Network Hospital or Ambulatory Surgical Center

When you get services from an In-Network Hospital or Ambulatory Surgical Center, certain Providers there may be Out-of-Network. In these cases, the most those Providers may bill you is your plan's In-Network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These Providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other types of services at these In-Network facilities, Out-of-Network Providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get Out-of-Network care. You can choose a Provider or facility in your plan's network.

WHEN BALANCE BILLING ISN'T ALLOWED, YOU ALSO HAVE THESE PROTECTIONS:

- You're only responsible for paying your share of the cost (like the Copayments, Cost Sharing, and Deductibles that you would pay if the Provider or facility was In-Network). Your health plan will pay any additional costs to Out-of-Network Providers and facilities directly.

- Generally, your health plan must:
- Cover emergency services without requiring you to get approval for services in advance (also known as "Prior Authorization").
- Cover emergency services by Out-of-Network Providers
- Base what you owe the Provider or facility (cost-sharing) on what it would pay an In-Network Provider or facility and show that amount in your explanation of benefits.
- Count any amount you pay for emergency services or Out-of-Network services toward your In-Network Deductible and Out-of-Pocket Limit.

If you believe you've been wrongly billed, you may contact the Idaho Department of Insurance by visiting the department's Web site at **www.doi.idaho.gov** or calling the department's telephone number at 1 (208) 334-4250 or toll-free in Idaho at 1 (800) 721-3272.

Visit **www.cms.gov/nosurprises** for more information about the No Surprises Act and your rights under federal law with respect to payment disputes.

WEIGHT MANAGEMENT PROGRAM
The Weight Management program, delivered as Intensive Behavioral Counseling (IBC), is designed to support individuals who are overweight or have obesity, particularly those with cardiac disease risk factors. Aligned with U.S. Preventive Services Task Force (USPSTF) Grade B recommendations, this program includes: • Structured, Evidence-Based Support: Monthly sessions focused on weight monitoring and self-monitoring strategies to sustain progress and prevent weight regain. • Participant Tools: Each participant receives a Bluetooth-enabled digital scale for at-home weight tracking, delivered upon enrollment. The scale is theirs to keep, with defective units replaced by the Network Partner. This comprehensive approach ensures participants receive consistent support and practical tools to improve health outcomes. To find out if you qualify, send an email to participantcare@soleranetwork.com or call 888-293-6044.

DIABETES PREVENTIVE PROGRAM (DPP)
This program is available at no cost to Participants who qualify. You'll be able to choose from an array of national and local programs. Find out if you qualify by taking a one (1) minute survey at www.Solera4me.com/bcidaho or call the Contract Administrator's Diabetes Prevention Program hotline at 833-868-6895. The Diabetes Prevention Program (DPP) program is a structured lifestyle intervention that includes dietary coaching, lifestyle intervention, and moderate physical activity, all with the goal of preventing the onset of diabetes in individuals who are pre-diabetic. The clinical intervention consists of sixteen (16) intensive "core" sessions of a curriculum in a group-based, classroom-style setting that Provides practical training in long-term dietary change, increased physical activity, and behavior change strategies for weight control. After the sixteen (16) core sessions, less intensive monthly follow-up meetings help ensure that the Participant maintain healthy behaviors. The primary goal of the intervention is a 5-7% average weight loss among Participants. Limited to one program, per Benefit Period, per Participant.

Blue Cross of Idaho
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Idaho AGC Self-Funded Benefit Trust Connected Care 2750

Idaho AGC
A PROUD CHAPTER OF AGC OF AMERICA

CONNECTED CARE MOUNTAIN VIEW NETWORK EAST MANAGED CARE BENEFITS OUTLINE Visit our Website at www.bcidaho.com to locate a Contracting Provider		
	In-Network	**Out-of-Network**
	The Participant is responsible to pay these amounts:	
Deductibles (per Benefit Period) **Individual**	$2,750	
Family *(No Participant may contribute more than the Individual Deductible amount toward the Family Deductible)*	$5,500	
Out-of-Pocket Limits (per Benefit Period) Includes applicable Deductible, Cost Sharing and Copayments. *(See Plan for services that do not apply to the limit)* **Individual** **Family** *(No Participant may contribute more than the Individual Out-of-Pocket Limit amount toward the Family Out-of-Pocket Limit)*	$8,500 $17,000	$17,000 $34,000
Cost Sharing *Unless specified otherwise below, the Participant pays the following Cost Sharing amount*	30% of Maximum Allowance after Deductible	50% of Maximum Allowance after Deductible
FREQUENTLY USED COVERED SERVICES - *Some services may require Prior Authorization.*		
Physician Office Visits *(Additional services, such as laboratory, x-ray, and other Diagnostic Services are not included in the Office Visit.)*	$30 Copayment for Primary Care Physician (PCP) $50 Copayment for Contracting Provider (non-PCP)	Deductible and Cost Sharing
TELEHEALTH SERVICES		
Telehealth Virtual Care Services	Telehealth Virtual Care Services are available for any category of covered outpatient services. The amount of payment and other conditions for in-person services will apply to Telehealth Virtual Care Services. Please see the appropriate section of the Benefits Outline for those terms.	

Preventive Care Covered Services **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); Abdominal Aortic Aneurysm Screening and Ultrasound; Unhealthy Alcohol and Drug Use 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 and/or self-harm; Anxiety Screening; Newborn Hearing Test; Lipid Disorder Screening; Nicotine, Smoking and Tobacco-use Cessation Counseling Visit; Dietary Counseling and Physical Activity Behavioral Counseling; Behavioral Counseling for Participants who are overweight or obese; Preventive Lead Screening; Lung Cancer Screening for Participants age 50 and over; Hepatitis C Virus Infection Screening; Urinary Incontinence Screening; For Enrollee 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; Perinatal Depression Counseling and Intervention; Behavioral Counseling for Healthy Weight and Weight Gain in Pregnancy.* *The specifically listed Preventive Care Services may be adjusted accordingly to coincide with federal government changes, updates, and revisions.* **For services not specifically listed**	No Charge (Deductible does not apply) Deductible and Cost Sharing	Deductible and Cost Sharing Deductible and Cost Sharing
Supplemental Breast Screening *(For Participants at heightened risk of breast cancer. Includes breast exam using standard or abbreviated MRI, contrast mammogram imaging or ultrasound.)* *One supplemental breast screening per Participant, per Benefit Period combined In-Network and Out of-Network.* *For additional exams, Diagnostic or Preventive Care Services apply as listed in the Benefits Outline)*	No Charge (Deductible does not apply)	Deductible and Cost Sharing

Immunizations *Acellular Pertussis, Anthrax, COVID-19, Cholera, Dengue, Diphtheria, Haemophilus Influenza B, Hepatitis A, Hepatitis B, Human papillomavirus (HPV), Inactivated Poliovirus, Influenza, Japanese Encephalitis, Measles, Meningococcal, Mpox, Mumps, Pneumococcal (pneumonia), Rabies, Rotavirus, RSV, Rubella, Tetanus, Typhoid, Varicella (Chicken Pox), Yellow Fever 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.* Other immunizations not specifically listed may be covered at the discretion of the Contract Administrator when Medically Necessary.	No Charge (Deductible does not apply) Deductible and Cost Sharing	No Charge (Deductible does not apply) Deductible and Cost Sharing

PRESCRIPTION DRUG BENEFITS

- The Standard Formulary is available at www.bcidaho.com, and is available to any Participant on request by contacting the Contract Administrator's Customer Service Department at (208) 286-3439 or (866) 283-6354.
- Each Non-Specialty Prescription Drug shall not exceed a 90 day supply at one (1) time.
- Each Specialty Prescription Drug shall not exceed a 30 day supply at one (1) time.
- **Retail Pharmacies:** One Copayment for each 30 day supply.
- **Mail Order:** 2.5x retail Copayments for a 90 day supply.
- Prescription Drug Services apply to the In-Network Out-of-Pocket Limits.

SPECIALTY PRESCRIPTION DRUGS

The Plan may increase the Cost Sharing listed below to take full advantage of any available drug cost share assistance program offered by drug manufacturers (either directly or indirectly through third parties). This feature, known as the Cost Relief Program, can lower overall costs to the Plan for certain Specialty Prescription Drugs. If a Participant enrolls in the Cost Relief Program, they will not be responsible for the additional Cost Sharing. If a Participant does not enroll, their Cost Sharing may increase, and may not count towards, their Deductible or Out-of-Pocket Limit.

Tier 1*	$10 Copayment per prescription
Tier 2*	$10 Copayment per prescription
Tier 3*	$35 Copayment per prescription
Tier 4*	$70 Copayment per prescription
Tier 5*	20% Cost Sharing per prescription
Tier 6*	50% Cost Sharing per prescription

***Specialty Prescription Drug Cost Relief Program**
Please note that certain Specialty Prescription Drugs are only available from an In-Network Specialty Pharmacy, and a Participant will not be able to get them at a Retail Pharmacy. For more information about applicable Cost Sharing amounts available to Specialty Drugs that are eligible for the Cost Relief Program, please see the "Drug Cost Relief Program" section in the Prescription Drug Benefits Section.

ACA Preventive Prescription Drugs	No Charge
Prescribed Contraceptives	No Charge

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.

COVERED SERVICES *Some services may require Prior Authorization.*	In-Network	Out-of-Network
	The Participant is responsible to pay these amounts:	
Allergy Injections	$5 Copayment per visit if this is the only service provided during the visit	Deductible and Cost Sharing
Ambulance Transportation Services • Ground Ambulance Services • Air Ambulance Services *(Payment for Out-of-Network Air Ambulance Services is based on the Qualifying Payment Amount.)*	Deductible and In-Network Cost Sharing. Cost Sharing accumulates towards the In-Network Out-of-Pocket Limit.	
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.)*	No Charge (Deductible does not apply)	Deductible and Cost Sharing
Chiropractic Care Services *Up to a combined In-Network and Out of-Network total of 24 visits per Participant, per Benefit Period. (Additional services, such as laboratory, x-ray and other Diagnostic Services are not included in the Office Visit.)*	$30 Copayment per visit	Deductible and Cost Sharing
Dental Services Related to Accidental Injury	Deductible and Cost Sharing	Deductible and Cost Sharing
Diabetes Self-Management Education Services *Up to a combined In-Network and Out of-Network total of 4 visits per Participant, per Benefit Period.*	$30 Copayment per visit	Deductible and Cost Sharing
Diagnostic Services - Laboratory and X-ray *(Including diagnostic mammograms)*	Deductible and Cost Sharing	Deductible and Cost Sharing
Durable Medical Equipment, Orthotic Devices and Prosthetic Appliances *(For wigs required due to a covered medical condition: One (1) wig per Participant, per Benefit Period, up to a combined annual benefit limit of $500)*	Deductible and Cost Sharing	Deductible and Cost Sharing
Emergency Services – Facility Services *(Copayment waived if admitted)* *(Payment for Out-of-Network Emergency Services is based on the Qualifying Payment Amount.)*	$150 Copayment per hospital Outpatient emergency room visit, then Deductible and In-Network Cost Sharing. Emergency Services accumulate towards the In-Network Out-of-Pocket Limit.	
Emergency Services – Professional Services *(Payment for Out-of-Network Emergency Services is based on the Qualifying Payment Amount.)*	Deductible and In-Network Cost Sharing. Emergency Services accumulate towards the In-Network Out-of-Pocket Limit.	
Growth Hormone Therapy	Deductible and Cost Sharing	Deductible and Cost Sharing
Hearing Aids *(Benefits are limited to one (1) device per ear, every three (3) years, per Participant, per Benefit Period. Benefits for Eligible Dependent Children also includes forty-five (45) speech therapy visits during the first twelve (12) months after delivery of the covered device. Refer to Outpatient Speech Therapy section for benefit details.)*	Deductible and Cost Sharing	Deductible and Cost Sharing
Home Health Skilled Nursing Care Services	Deductible and Cost Sharing	Deductible and Cost Sharing

COVERED SERVICES *Some services may require Prior Authorization.*	In-Network ***The Participant is responsible to pay these amounts:***	Out-of-Network ***The Participant is responsible to pay these amounts:***
Home Intravenous Therapy	Deductible and Cost Sharing	Deductible and 80% Cost Sharing
Hospice Services	No Charge (Deductible does not apply)	Deductible and Cost Sharing
Hospital Services	Deductible and Cost Sharing	Deductible and Cost Sharing
Inpatient Rehabilitation or Habilitation Services	Deductible and Cost Sharing	Deductible and Cost Sharing
Maternity Services and/or Involuntary Complications of Pregnancy *(Physician Services including prenatal, delivery, and postnatal care)*	$500 Copayment	Deductible and Cost Sharing
Mental Health and Substance Use Disorder Inpatient Services • **Inpatient Facility and Professional Services**	Deductible and Cost Sharing	Deductible and Cost Sharing
Mental Health and Substance Use Disorder Outpatient Services • **Outpatient Psychotherapy Services** • **Facility and other Professional Services**	$30 Copayment per visit Deductible and Cost Sharing	Deductible and Cost Sharing
Outpatient Applied Behavioral Analysis (ABA)	$30 Copayment per visit	Deductible and Cost Sharing
Treatment for Autism Spectrum Disorder	Covered the same as any other illness, depending on the services rendered. Please see the appropriate section of the Benefits Outline. Visit limits do not apply to Treatments for Autism Spectrum Disorder, and related diagnoses.	
Outpatient Cardiac Rehabilitation Services *(Additional services, such as, x-ray and other Diagnostic Services are not included in the Therapy Services Copayment)*	$10 Copayment per visit	Deductible and Cost Sharing
Outpatient Habilitation Therapy Services • Outpatient Occupational Therapy • Outpatient Physical Therapy • Outpatient Speech Therapy *Up to a combined In-Network and Out-of-Network total of 20 visits per Participant, per Benefit Period.*	Deductible and Cost Sharing	Deductible and Cost Sharing
Outpatient Pulmonary Rehabilitation Services *(Additional services, such as, x-ray and other Diagnostic Services are not included in the Therapy Services Copayment)*	$10 Copayment per visit	Deductible and Cost Sharing
Outpatient Rehabilitation Therapy Services • Outpatient Occupational Therapy • Outpatient Physical Therapy • Outpatient Speech Therapy *Up to a combined In-Network and Out-of-Network total of 20 visits per Participant, per Benefit Period.*	Deductible and Cost Sharing	Deductible and Cost Sharing
Outpatient Respiratory Therapy Services	Deductible and Cost Sharing	Deductible and Cost Sharing
Palliative Care Services	No Charge (Deductible does not apply)	Deductible and Cost Sharing
Post-Mastectomy/Lumpectomy Reconstructive Surgery	Deductible and Cost Sharing	Deductible and Cost Sharing

This information is for comparison purposes only and not a complete description of benefits. All descriptions of coverage are subject to the provisions of the corresponding plan, which contains all the terms and conditions of coverage and exclusions and limitations. Certain services not specifically noted may be excluded. Please refer to the plan issued for a complete description of benefits, exclusions limitations and conditions of coverage. If there is a difference between this comparison and its corresponding plan, the plan will control.

COVERED SERVICES *Some services may require Prior Authorization.*	In-Network	Out-of-Network
	The Participant is responsible to pay these amounts:	
Prescribed Contraceptive Services *(Includes diaphragms, intrauterine devices (IUDs), implantables, injections and tubal ligation)*	No Charge (Deductible does not apply)	Deductible and Cost Sharing
Skilled Nursing Facility *Up to a combined In-Network and Out-of-Network total of 30 days per Participant, per Benefit Period.*	Deductible and Cost Sharing	Deductible and Cost Sharing
Sleep Study Services	Deductible and Cost Sharing	Deductible and Cost Sharing
Surgical/Medical Services *(Professional Services)*	Deductible and Cost Sharing	Deductible and Cost Sharing
Temporomandibular-Joint (TMJ) Services *Up to a combined Lifetime Benefit Limit of $2,000 per Participant.*	Deductible and Cost Sharing	Deductible and Cost Sharing
Therapy Services *(Including Radiation, Chemotherapy, and Renal Dialysis)*	Deductible and Cost Sharing	Deductible and Cost Sharing
Transplant Services	Deductible and Cost Sharing	Deductible and Cost Sharing
Be aware that your actual costs for services provided by an Out-of-Network Provider may exceed the Plan's Out-of-Pocket Limit for Out-of-Network services. Except as provided by the No Surprises Act, Out-of-Network Providers can bill you for the difference between the amount charged by the Provider and the amount allowed by the Contract Administrator, and that amount is not counted toward the Out-of-Network Out-of-Pocket Limit.		

DISCRIMINATION IS AGAINST THE LAW

Blue Cross of Idaho complies with applicable Federal civil rights laws and does not discriminate, exclude or treat less favorably on the basis of race, color, national origin (including limited English proficiency and primary language), age, disability or sex.

Blue Cross of Idaho:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services 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 assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Blue Cross of Idaho Civil Rights Coordinator at 1-800-627-1188 (TTY: 711).

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 at:

Civil Rights Coordinator
3000 E. Pine Ave., Meridian, ID 83642
Telephone: 1-800-274-4018
Fax: 208-331-7493
Email: ***grievancesandappeals@bcidaho.com***
TTY: 711

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator 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 (TDD). Complaint forms are available at ***https://www.hhs.gov/ocr/complaints/index.html.***

ATTENTION: If you speak Arabic, Bantu, Chinese, Farsi, French, German, Japanese, Korean, Nepali, Romanian, Russian, Serbo-Croatian, Spanish, Tagalog, or Vietnamese, language assistance services, free of charge, are available to you. Call 1-800-627-1188 (TTY: 711).

Arabic انتبه: إذا كنت تتحدث اللغة العربية ، فإن خدمات المساعدة اللغوية متاحة لك مجانًا اتصل على 1-800-627-1188 (للصم والبكم: 711).

Bantu: ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona 1-800-627-1188 (TTY: 711).

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 1-800-627-1188 (TTY：711)。

Farsi توجه: اگر به زبان فارسی صحبت می کنید، خدمات رایگان پشتیبانی زبان، در دسترس شما است. شماره تماس 1-800-627-1188 (TTY:711).

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-627-1188 (ATS : 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-627-1188 (TTY: 711).

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。1-800-627-1188（TTY:711）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. 1-800-627-1188 (TTY: 711)번으로 전화해 주십시오.

Nepali: ध्यान दनिुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको नमिर्ता भाषा सहायता सेवाहरू नःशिुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-800-627-1188 (टटिवाइ: 711) ।

Romanian: ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-627-1188 (TTY: 711).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-627-1188 (телетайп: 711).

Serbo-Croatian: OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-627-1188 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-627-1188 (TTY: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-627-1188 (TTY: 711.

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-627-1188 (TTY: 711).

Y0010_MK25507_C

Form No. 3-1187 (08-25)

Attachment A:

NON-EMERGENCY SERVICES REQUIRING PRIOR AUTHORIZATION ANNUAL NOTICE

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

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

The Contract Administrator will respond to a request for Prior Authorization for the services listed below received from either the Provider or the Participant within two (2) business days 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 Contract Administrator's Website at www.bcidaho.com.

Prior Authorization is not a guarantee of payment. It is a pre-service determination of Medical Necessity based on information provided to the Contract Administrator at the time the Prior Authorization request is made. The Contract Administrator retains the right to review the Medical Necessity of services, eligibility of services and benefit limitations and exclusions after services are received. When Prior Authorization for a Covered Service is required of and obtained by or on behalf of a Participant, we will provide benefits in accordance with the Prior Authorization and the terms of the Plan after the Covered Service has been provided except in cases of fraud, intentional misrepresentation, nonpayment of Contribution, exhaustion of benefits or if the Participant for whom the Prior Authorization was granted is not enrolled at the time the Covered Service was provided.

The following listing includes specific Procedures and Services, as well as a few general categories or examples of Procedures and Services, that require Prior Authorization. In the case of general categories or examples, call Customer Service at the telephone number listed on the back of the Participant's Identification Card to confirm if a specific Procedure or Service requires Prior Authorization.

Procedures:

- Radiation therapy
- Dental Surgery related to an accident
- Treatment of veins
- Reconstructive and plastic Surgery, including breast, eyelid, jaw and sinus
- Surgery for snoring or sleep problems
- Transplants (organ, tissue, etc.)
- Gender affirming services
- Other Inpatient and Outpatient surgical procedures
- Certain genetic and laboratory testing
- Certain cardiology procedures and testing
- Wound Care and Hyperbaric Oxygen (HCO)

Services:

- Acute Inpatient hospitalization
- Long-term acute care hospital (LTACH) admissions
- Rehabilitation and long-term care facility admissions
- Skilled nursing facility admissions
- Sub-acute and transitional care admissions

- Non-emergency ambulance transport

Durable Medical Equipment:

- Certain equipment with costs of more than one thousand dollars ($1,000) (including rent-to-purchase items)
- Certain Orthotic Devices and Prosthetic Appliances with costs of more than one thousand dollars ($1,000)

Pharmacy

- Certain Prescription Drugs (find a full list at ***members.bcidaho.com***)
- Chimeric antigen receptor (CAR) T-cell Therapy
- Growth hormone therapy
- Outpatient intravenous (IV) therapy for infusion drugs (find a list at ***members.bcidaho.com***)

Plan Name: Idaho AGC Self-Funded Benefit Trust Plan

Trust: Idaho AGC Self-Funded Benefit Trust

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

Contract Administrator: Blue Cross of Idaho Health Service, Inc.

CCO

Effective Date: January 1, 2026

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

This is a self-funded plan and is not an insurance policy and the Idaho AGC Self-Funded Benefit Trust does not participate in the Idaho Life and Health Guaranty Association.

TABLE OF CONTENTS

HOW TO SUBMIT CLAIMS

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

1. The Provider can file the claims for the Participant. Most Providers will submit a claim on a Participant's behalf if the Participant shows them the identification card and asks them to send the Contract Administrator the claim.

2. The Participant can send the Contract Administrator the claim.

TO FILE A PARTICIPANT'S OWN CLAIMS

If a Provider prefers that a Participant file the claim, here is the procedure to follow:

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

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

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

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

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

HOW BLUE CROSS OF IDAHO NOTIFIES THE PARTICIPANT

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

CONTACT INFORMATION FOR THE CONTRACT ADMINISTRATOR

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

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

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

Mailing Address
PO Box 7408
Boise, ID 83707
(208) 286-3439 (Boise Area)
1(866) 283-6354

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 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

The Employer decides which categories of its Employees identified in Section I.A. (Eligible Employee) and Dependents identified in Section I.B. (Eligible Dependent) will have the opportunity to apply for coverage under this Plan. The Employer will determine if there are certain probationary periods that must be satisfied before a new Eligible Employee can qualify for coverage under this Benefit Trust Plan. The Employer will timely communicate such eligibility categories and probationary periods to the Trust in writing. Please contact your manager of employee benefits for eligibility, probationary period, and any other applicable restrictions.

A. Eligible Employee

An Eligible Employee is eligible for coverage 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.

(see the Plan for additional Eligibility and Enrollment provisions)

B. Eligible Dependent

To qualify as an Eligible Dependent, 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 Domestic Partner under a valid Affidavit of Domestic Partnership.
3. The Participating Employee's or the Employee's spouse or the Employee's Domestic Partner's natural child, stepchild, legally adopted child, child placed with the Participating Employee or the Participating Employee's spouse or the Participating Employee's Domestic Partner for adoption, or child for whom the Participating Employee or the Participating Employee's spouse or the Participating Employee's Domestic Partner has court-appointed guardianship or custody. The child must be under the age of twenty-six (26).
4. A child as described in the first sentence of subparagraph three (3) who has attained age twenty-six (26) provided:
    a) The child is medically certified as incapable of self-sustaining employment due to an intellectual disability or physical handicap that began prior to age twenty-six (26);
    b) The child is chiefly dependent upon the Participating Employee or the Participating Employee's spouse or the Participating Employee's Domestic Partner for support and maintenance; and
    c) The Participating Employee submits proof of such child's incapacity and dependency as described in this subparagraph four (4) within thirty-one (31) days of such child's attainment of age twenty-six (26) and as subsequently required by the Contract Administrator and/or the Employer at reasonable intervals.

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 on the last day of the month in which the change in eligibility status took place.

C. Annual Open Enrollment Periods

Applications for coverage for an Eligible Employee will only be accepted during the 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 Benefit Trust Plan.

E. Enrollment of Eligible Dependents

1. For an Eligible Employee to enroll himself or herself and any Eligible Dependents for coverage under this Benefit Trust 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 Employer.
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 (1st) through the fifteenth (15th) day of the month. No Contribution is required if the child's date of birth falls on the sixteenth (16th) 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 Benefit Trust Plan from and after the date of birth for sixty (60) days.
    A. Contribution for the first sixty (60) days of coverage is due not less than thirty-one (31) days following receipt of a billing for the required Contribution. In order to continue coverage beyond the sixty (60) days outlined above, the 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 Benefit Trust 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 Benefit Trust 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 an Eligible Employee's application for coverage is submitted to the Contract Administrator by the Employer on or before the Plan Date for the Employer, the Effective Date of coverage for an Eligible Employee and any Eligible Dependents listed on the application is the Employer's 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 marriage or the loss of other health insurance or group health insurance, the Effective Date of coverage will be the first day of the month following the marriage or loss of coverage.
4. If enrollment is requested during a Special Enrollment Period due to the acquisition of a new Eligible Dependent through birth, adoption, or placement for adoption, the Effective Date of coverage will be the date of birth for a newborn natural child, the date of adoption, or the date of placement for adoption, so long as the request is made within sixty (60) days of the child's date of birth, adoption, or placement for adoption.
5. For other enrollment requested through 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 other health insurance or group health insurance at the time of the initial enrollment period.
   b) The individual lost eligibility for that other coverage (or the employer stopped contributing toward the Eligible Employee's or Eligible Dependent's other coverage). An individual's nonpayment of contributions toward the other coverage does not constitute a loss of eligibility, if the individual is otherwise eligible for such coverage.
   c) The individual requests enrollment within thirty (30) days after the other coverage ends (or after the employer stops contributing toward the other coverage). If the Special Enrollment Right is due to a spouse's loss of coverage, the Eligible Employee may enroll themselves and any or all of their Eligible Dependents.

2. Addition of an Eligible Dependent through marriage, birth, adoption or placement of adoption and enrollment is requested no later than sixty (60) days after the event. The Eligible Employee may enroll themselves and any or all of their Eligible Dependents.
3. A court has issued a Qualified Medical Child Support Order (QMCSO) requiring that coverage be provided for an Eligible Dependent by a Participant, and application for enrollment is made within thirty (30) days after issuance of the QMCSO.
4. The Eligible Employee and/or Eligible Dependent become eligible for financial assistance under Medicaid or the Children's Health Insurance Program (CHIP) and coverage is requested no later than sixty (60) days after the date the Eligible Employee and/or Eligible Dependent is determined to be eligible for such assistance.
5. Coverage under Medicaid or CHIP for an Eligible Employee and/or Eligible Dependent is terminated as a result of loss of eligibility for such coverage, and coverage is requested no later than sixty (60) days after the date of termination of such coverage.

II. 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.

B. 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 Benefit Trust Plan, unless required by State or Federal law.

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

D. 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 Benefit Trust 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.

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. Military personnel called into active duty will continue to be covered to the extent required by the Uniformed Services Employment and Reemployment Rights Act (USERRA) or other applicable law.

III. Qualified Medical Child Support Order

A. If this Benefit Trust Plan provides for Family Coverage the Contract Administrator 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 judgment, 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 Benefit Trust 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 Benefit Trust 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, the Contract Administrator will notify the party who sent the order and each affected child of the receipt and of the criteria by which the Contract Administrator determines if the medical child support order is a QMCSO. In addition, the Contract Administrator 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 the Contract Administrator. 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, the Contract Administrator 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. The Contract Administrator, 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.

IV. Other Eligibility Provisions

All Participants must maintain their principal residence in the Service Area to be eligible for coverage in this Benefit Trust Plan.

INPATIENT NOTIFICATION SECTION

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

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

I. Non-Emergency Preadmission Notification

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

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

II. Emergency Admission Notification

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

This notification alerts the Contract Administrator to the emergency stay.

If the Participant is outside the Service Area, the Contract Administrator's medical management department must be notified of the emergency room services within twenty-four (24) or by the end of the first working day following care if admitted.

III. Continued Stay Review

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

IV. Discharge Planning

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

PRIOR AUTHORIZATION SECTION

I. Prior Authorization

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

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

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

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

The notification may be completed by telephone call or in writing and must include the information necessary to establish that the proposed services are Covered Services under the Participant's Plan and Medically Necessary. The Contract Administrator will respond to a request for Prior Authorization received from either the Provider or the Participant within two (2) business days of the receipt of the medical information necessary to make a determination.

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

Prior Authorization is not a guarantee of payment. It is a pre-service determination of Medical Necessity based on information provided to the Contract Administrator at the time the Prior Authorization request is made. The Contract Administrator, on behalf of the Trust, retains the right to review the Medical Necessity of services, eligibility of services and benefit limitations and exclusions after services are received. When Prior Authorization for a Covered Service is required of and obtained by or on behalf of a Participant, we will provide benefits in accordance with the Prior Authorization and the terms of the Plan after the Covered Service has been provided except in cases of fraud, intentional misrepresentation, nonpayment of Contribution, exhaustion of benefits or if the Participant for whom the Prior Authorization was granted is not enrolled at the time the Covered Service was provided.

II. Referral Procedures

A. Non-Emergency Services Network Gap Exception

To receive Covered Services at the In-Network benefit level from a Noncontracting Provider, your Primary Care Physician (PCP) may request a referral from the Contract Administrator when there is no Provider within your Plan's Provider Network capable of providing the services. The Contract Administrator will respond to a referral request received from either the PCP or the Participant within fourteen (14) business days of the receipt of the medical information necessary to make a

determination. The Contract Administrator's referral determination will be sent to both the Participant and PCP. The Contract Administrator will evaluate referral requests that are outside of the Plan's Provider Network to determine if the services may be performed by an In-Network Provider. If the Contract Administrator determines that there is no In-Network Provider capable of providing the service, the Contract Administrator will evaluate the referred Provider in accordance with quality and efficiency standards listed on the Referrals page of the Contract Administrator Website at: www.bcidaho.com. If the referral to the Noncontracting Provider meets this criteria, the Contract Administrator will allow the network gap exception and In-Network benefits will be applied to the services.

Non-emergency Covered Services provided by a Provider not contracting with the local Blue Cross/Blue Shield plan are eligible for Out-of-Network benefits.

Except as provided by the federal No Surprises Act, the Participant is responsible for the Copayment, Deductible, and/or Cost Sharing, as applicable, and may be responsible for any charges that exceed the Maximum Allowance when a referral is not obtained by the Participant or not accepted by the Provider for services provided by a Provider not contracting with the local Blue Cross/Blue Shield plan.

B. Emergency Services

For all emergency services, Covered Services provided by a Noncontracting Provider or Provider not contracting with the local Blue Cross/Blue Shield plan are eligible for In-Network Services without a referral from your PCP.

Participants may self-refer for emergency services.

MEDICAL BENEFITS SECTION

This section specifies the benefits a Participant is entitled to receive for the Covered Services described, or conditions that must be satisfied to qualify for benefits, subject to the other provisions of this Benefit Trust 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 cover page of this Benefit Trust Plan for the Benefit Period. If the Participant's Effective Date is after the Plan Date, the initial Benefit Period for that Participant may be less than twelve (12) months.

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

II. Deductible

The Deductible(s) are shown in the Benefits Outline.

III. Out-of-Pocket Limit

The Out-of-Pocket Limit is shown in the Benefits Outline. Eligible Out-of-Pocket expenses include only the Participant's Deductible, Copayments and Cost Sharing, if applicable, for eligible Covered Services. When the Out-of-Pocket Limit is met, benefits payable for Covered Services increase to 100% of the Maximum Allowance during the remainder of the Benefit Period, except for services that do not apply to the limit as listed in the Plan. If a Participant is admitted as an Inpatient at the end of a Benefit Period and the hospitalization continues uninterrupted into the succeeding Benefit Period, all eligible Out-of-Pocket expenses incurred for Inpatient Hospital Services are considered part of the Benefit Period in which the date of admission occurred.

Out-of-Pocket expenses associated with the following are not included in the 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(such as dental and vision).
4. Noncovered services or supplies.
5. Any separate Prescription Drug Out-of-Pocket Limits, if applicable, as listed in the Benefits Outline.

IV. Providers

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

V. Covered Services

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

To be eligible for benefits, Covered Services must be Medically Necessary and must be provided to an eligible Participant under the terms of the Plan. Coverage includes Medically Necessary care and treatment of a Congenital Anomaly for newborn and newly adopted children.

The Benefits Outline, incorporated into this Benefit Trust 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.

A. Ambulance Transportation Services

Ambulance transportation services are covered for Medically Necessary transportation of a Participant as follows:

1. Emergency Ground Ambulance transportation services when all of the following criteria are met:

a. The medical transport services comply with all applicable laws and must have all the appropriate, valid licenses and permits,
b. The ambulance or other medical transport services must have the necessary patient care equipment and supplies,
c. The Participant is experiencing an Emergency Medical Condition and any other form of transportation would be medically contraindicated, and
d. The Participant must be transported to the nearest hospital with the appropriate facilities for the treatment of the Participant's Illness or Injury or, in the case of organ transplantation, to the approved transplant facility, unless the nearest appropriate hospital is on divert or has no available beds or accepting Physician. Consideration can be made to allow a Participant to remain within a specific hospital network.

2. Emergency Air Ambulance transportation services from the site of an accident, Injury or Illness, provided:
   a. All of the above criteria for Emergency Ground Ambulance transportation services are met, and
   b. The Participant is in critical condition and/or has unstable vital signs, respiratory status or cardiac status, and either:
      i. The point of pick-up is inaccessible by land vehicle, or Ground Ambulance transportation is precluded due to adverse weather and/or road conditions (e.g., flooding, ice, or snow), or
      ii. Transportation by Ground Ambulance poses a threat to the Participant's survival or seriously endangers the Participant's health due to the time, distance, or instability of transportation by ground. Generally, the time and distance requirements are met if the total estimated time for transportation from the site of accident, Injury, or Illness is projected to be at least thirty (30) minutes shorter for Air Ambulance than for Ground Ambulance.
3. Emergency Air Ambulance transportation services from a health care Facility, hospital emergency department, or Inpatient setting, when all of the following criteria are met:
   a. The Participant is in critical condition, has unstable vital signs, unstable respiratory or cardiac status,
   b. The Participant requires acute medical or surgical intervention(s) that the transferring facility cannot provide,
   c. The Participant is being transferred to the nearest equivalent or higher level of acuity Inpatient facility unless the nearest appropriate hospital is on divert, has no available beds or accepting Physician, or the Air Ambulance cannot land (except consideration can be made to allow a Participant to remain within a specific hospital network), and
   d. Transportation by Ground Ambulance poses a threat to the Participant's survival or seriously endangers the Participant's health due to the time, distance, or instability of transportation by ground. Generally, the time and distance requirements are met if the total estimated time for transportation from the originating to the receiving facility is projected to be at least thirty (30) minutes shorter for Air Ambulance than for Ground Ambulance.
4. Ground Ambulance transportation services or Air Ambulance transportation services that are not for an Emergency Medical Condition must be Medically Necessary and require Prior Authorization.
5. In determining whether ambulance transportation services are covered under the Plan, the Contract Administrator considers the medical records and documents including Blue Cross of Idaho Medical Policy regarding ambulance and medical transport services.

Ambulance transportation services are not Medically Necessary in some circumstances including the following:

a. Transportation from a hospital, capable of treating the Participant to another hospital primarily for the convenience of the Participant or Participant's family, Physician, or other health care provider, or because the Participant and/or Participant's family prefer a specified hospital or Physician,

b. Non-medical transport services such as those provided by medical vans or commercial transportation,
c. Transportation or transfers to or from (i) a Skilled Nursing Facility (SNF), (ii) Physician's office, (iii) any other facilities, and/or (iv) the Participant's home (which includes a private residence or domicile, assisted living facility, or long-term care facility) for any reason including but not limited to outpatient treatment, procedures, or tests,
d. Transportation of a deceased Participant when the Participant was pronounced dead at the scene,
e. Transportation to a facility that is not an acute care hospital with appropriate facilities to treat the condition for which the transfer was made,
f. Transportation related to search and rescue operations, and
g. Transportation to a facility that is not the closest location capable of providing the level of care required.

B. Applied Behavioral Analysis (ABA) - Outpatient

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

C. 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.

D. Breastfeeding Support and Supply Services

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

E. 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 Benefit Trust 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 Benefit Trust Plan.

F. 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 Benefit Trust 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, unless the source of the injury is an act of domestic violence. 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 shall be secondary to dental benefits available to a Participant under another benefit section or available under a dental policy of insurance, policy, or underwriting plan that is separate and distinct from this Benefit Trust Plan.

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

H. Durable Medical Equipment

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

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

I. Hearing Aids

Hearing aids, auditory osseointegrated (bone conduction) devices, cochlear implants and examination for the fitting for congenital or acquired hearing loss are a Covered Service. Benefits for Eligible Dependent Children also includes forty-five (45) speech therapy visits during the first twelve (12) months after delivery of the covered device.

J. 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.

K. Hospice Services

1. **Conditions**

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

a) The attending or primary Physician must certify that the Participant is a terminally ill patient with a life expectancy of six (6) months or less.
b) The Participant must live within the Hospice's local geographical area.
c) The Participant must be formally accepted by the Hospice.
d) The Participant must have a designated volunteer Primary Care Giver at all times.

2. **Exclusions and Limitations**

No benefits are provided for:

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

L. Hospital Services

1. Inpatient Hospital Services

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

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

(1) A room with two (2) or more beds is covered. If a private room is used, the benefit provided in this section for a room with two (2) or more beds will be applied toward the charge for the private room. Any difference between the charges is a noncovered expense and is the sole responsibility of the Participant.
(2) If isolation of the Participant is: (a) required by the law of a political jurisdiction, or (b) required to prevent contamination of either the Participant or another patient by the Participant, then payment for approved private room isolation charges shall be in place of the benefits for the daily room charge stated in paragraph one (1).
(3) Benefits for a bed in a Special Care Unit shall be in place of the benefits for the daily room charge stated in paragraph one (1).
(4) A bed in a nursery unit is covered.

b) **Ancillary Services**

Licensed General Hospital services and supplies including:

(1) Use of operating, delivery, cast, and treatment rooms and equipment.
(2) Prescribed drugs administered while the Participant is an Inpatient.
(3) Administration and processing of whole blood and blood products when the whole blood or blood products are actually used in a transfusion for a Participant; whole blood or blood plasma that is not donated on behalf of the Participant or replaced through contributions on behalf of the Participant.
(4) Anesthesia, anesthesia supplies and services rendered by the Licensed General Hospital as a regular hospital service and billed by the same hospital in conjunction with a procedure that is a Covered Service.
(5) All medical and surgical dressings, supplies, casts, and splints that have been ordered by a Physician and furnished by a Licensed General Hospital.

Specially constructed braces and supports are not Covered Services under this section.

(6) Oxygen and administration of oxygen.

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

(8) Diagnostic Services and Therapy Services.

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

c) **Special Services**

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

(1) Brittle diabetes.

(2) History of a life-endangering heart condition.

(3) History of uncontrollable bleeding.

(4) Severe bronchial asthma.

(5) Children under ten (10) years of age who require general anesthetic.

(6) Other non-dental life-endangering conditions that require hospitalization, subject to approval by the Contract Administrator.

2. **Outpatient Facility Services**

a) For Surgery or use of a licensed Outpatient birthing center, Ambulatory Surgical Facility or use of an observation room/area.

b) **Emergency Services**

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

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

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

M. Inpatient Rehabilitation or Habilitation Services

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

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

N. Medical Foods

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

O. Mental Health and Substance Use Disorder Services

1. Covered Mental Health and Substance Use Disorder Services include Intensive Outpatient Program (IOP), Partial Hospitalization Program (PHP), Residential Treatment Center, psychological testing/neuropsychological evaluation testing and Electroconvulsive Therapy (ECT).
2. **Inpatient Mental Health and Substance Use Disorder Care—**The benefits provided for Inpatient hospital services and Inpatient medical services in this section are also provided for the care of Mental or Nervous Conditions, Alcoholism, Substance Use Disorder or Addiction, or any combination of these.
3. **Outpatient Mental Health and Substance Use Disorder Care—**The benefits provided for Outpatient Hospital Services and Outpatient Medical Services in this section are also provided for Mental or Nervous Conditions, Alcoholism, Substance Use Disorder or Addiction, or any combination of these. The use of Hypnosis to treat a Participant's Mental or Nervous Condition is a Covered Service.
4. **Outpatient Psychotherapy Services—**Covered Services include professional office visit services, family, individual and/or group therapy.

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.

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

Q. 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.

R. Palliative Care Services

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

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

S. 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.

T. 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.

U. Professional Services

For In-Network Services provided by the Primary Care Physician (PCP), benefits may require a PCP Copayment per visit as shown in the Benefits Outline.

For In-Network Services provided by a Contracting Professional Provider other than the PCP, or with the Contract Administrator approved referral by the Participant's PCP by a Noncontracting Professional Provider, benefits may require a Contracting Provider Copayment per visit as shown in the Benefits Outline.

Covered Services include the following:

1. **Office/Home Medical Care**
   Covered Services include:
   a) Office Visits.
   b) consultations.
   c) after-hours Office Visits for emergency care.
   d) covered medical supplies such as dressings, casts, splints, braces, bandages and crutches that are furnished during an Office Visit in conjunction with medical services in quantities appropriate for the treatment of an acute medical condition.
   e) **Preventive Care Services**
      Benefits are provided for:
      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.
3. One (1) Supplemental Breast Screening per Benefit Period for a Participant at Heightened Risk of Breast Cancer. For purposes of this coverage, a "Supplemental Breast Screening" means a Medically Necessary and clinically appropriate examination of the breast using either standard or abbreviated magnetic resonance imaging, contrast mammogram imaging, or, if such imaging, is not possible, ultrasound, when there is no abnormality seen or suspected in the breast. In addition, a "Heightened Risk of Breast Cancer" means the Participant is believed to be at an increased risk of breast cancer due to personal history of atypical breast histologies, personal history or family history of breast cancer, genetic predisposition for breast cancer, prior therapeutic thoracic radiation therapy, lifetime risk of breast cancer of twenty percent (20%) or more according to risk assessment tools based on family history, extremely dense breast tissue based on recognized breast composition

categories, or heterogeneous dense breast tissue based on breast composition categories in combination with recognized risk factor.

4. **Injections**
5. **Surgical Services**

Covered Services include Inpatient or Outpatient Surgeries, and the administration of blood and blood plasma. Coverage includes:

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

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

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

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

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

f) **Second and Third Surgical Opinion**—

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

(2) Specifications:

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

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

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

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

6. **Diagnostic Services**

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

7. **Maternity Services and/or Involuntary Complications of Pregnancy**

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.

Nursery care of a newborn infant is not a maternity service.

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.

8. **Inpatient Medical Services**
9. **Telehealth Virtual Care Services**

V. Prosthetic Appliances

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

Benefits for Prosthetic Appliances are subject to the following limitations:

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

W. Skilled Nursing Facility

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

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

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

X. 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.

Y. 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.

Z. Therapy Services

Covered Services include:

1. **Physical Therapy**

   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:

   a) a Physician;
   b) a Licensed Physical Therapist provided the Covered Services are directly related to a written treatment regimen prepared by the Therapist; or
   c) a Podiatrist.

   No benefits are provided for:

   a) The following Physical Therapy Services when the specialized skills of a Licensed Physical Therapist are not required:
      (1) 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;
      (2) Assistance in walking such as that provided in support for feeble or unstable patients.
   b) 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.
   c) General exercise programs, even when recommended by a Physician or a Chiropractic Physician, and even when provided by a Licensed Physical Therapist.
   d) Maintenance, palliative or supportive care.
   e) Behavioral modification services.

2. **Occupational Therapy**

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:

a) A Physician.

b) A Licensed Occupational Therapist provided the Covered Services are directly related to a written treatment regimen prepared by the Occupational Therapist.

No benefits are provided for:

a) 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.

b) General exercise programs, even when recommended by a Physician or a Chiropractic Physician, and even when provided by a Licensed Occupational Therapist.

(c) Maintenance, palliative or supportive care.

(d) Behavioral modification services.

3. **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.

4. **Renal Dialysis**

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

5. **Chemotherapy**

6. **Radiation Therapy**

7. **Growth Hormone Therapy**

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

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

9. **Respiratory Therapy**

AA. 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.

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

2. **Transplants**

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

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

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

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

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

3. **Exclusions and Limitations**

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

No benefits are available for the following:

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

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

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

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

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

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

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

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

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

AB. Treatment for Autism Spectrum Disorder

Treatment for Autism Spectrum Disorder, and related diagnoses.

VI. Out-of-Area Care - Outside the state of Idaho

Provider Reimbursement

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

For Covered Services furnished outside the state of Idaho by a Provider who has an agreement for claims payment with the Blue Cross and/or Blue Shield plan in the area where the Covered Services were rendered, the Contract Administrator shall pay the local Blue Cross and/or Blue Shield plan's contractual charge or the actual charge, whichever is less, minus the Participant's Copayment, Deductible, and/or Cost Sharing, as applicable.

For Covered Services furnished outside the state of Idaho by a Provider who does not have an agreement for claims payments with the Blue Cross and/or Blue Shield plan in the area where the Covered Services were rendered, the Contract Administrator shall pay the Maximum Allowance minus the Participant's Copayment, Deductible, and/or Cost Sharing, as applicable. Except as provided by the federal No Surprises Act, the Participant may be responsible for charges that exceed the Maximum Allowance.

PRESCRIPTION DRUG BENEFITS SECTION

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 Benefit Trust 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 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 the Plan by mail order due to circumstances such as unstable shelf life, and required special storage conditions.

IV. Drug Cost Share Assistance Program

If a Participant qualifies for certain non-needs-based drug cost share assistance programs offered by drug manufacturers (either directly or indirectly through third parties), the PBM, at the direction of the Plan, may contact the Participant regarding enrollment in a drug cost relief program (the "Program"). The Program allows Participants to further reduce costs and may eliminate out-of-pocket costs altogether. The PBM will work with manufacturers to get the maximum drug cost share assistance available and will manage enrollment and renewals, when possible, on the behalf of Participants. The list of Prescription Drugs covered by the Program may be updated periodically. Please visit the Contract Administrator's Website, members.bcidaho.com, then click on the Pharmacy link, or call the PBM at 1-877-638-4008 for Program details.

Participants currently taking one or more Prescription Drugs included in this Program will have the opportunity to enroll in the program and will receive a welcome letter, followed up with a phone call to provide specific information about the Program as it pertains to applicable medication(s) from the PBM.

Any cost share assistance the Participant receives from the Program will not accumulate to their Deductible and Out-of-Pocket limit. Participation in this Program could exhaust a Participant's access to a manufacturer's copay assistance later in a year when they may no longer have coverage under the Plan or another health plan.

Nonparticipation
Participation in this Program is voluntary. However, Participants that do not enroll in the Program will be responsible for the increased portion of the cost of the Specialty Drug. The cost will depend on the Specialty Drug prescribed and the level of cost share assistance that would have been available to the Participant under the Program but will not be more than forty-five percent (45%) of the Allowed Charge.

Because certain Specialty Drugs under the Program are not classified as "essential health benefits" in accordance with the Affordable Care Act, Participant Cost Sharing for Specialty Drugs under the Program do

not count towards a Participant's Deductible or Out-of-Pocket Limit. If a Participant has already met their Deductible and/or Out-of-Pocket Limit with other claims, they will still be required to pay a portion of the cost for these Specialty Drugs. A list of Specialty Drugs that are not considered to be "essential health benefits" under the Program is available.

V. Amount of Payment

Except for Specialty Prescription Drugs available under the Program described in Section IV, the Contract Administrator or its designated Pharmacy Benefits Manager (PBM), 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 the Contract Administrator or its PBM. 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. 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 the Contract Administrator requesting reimbursement of any amounts the Participant believes were incorrect. Refer to the Inquiry and Appeals Procedures in the General Provisions Section.

D. 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.

VI. Mandatory Generic Drug Substitution

Certain Prescription Drugs are restricted to Generics for payment by the Contract Administrator. 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.

VII. 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. The Contract Administrator, on behalf of the Trust, reserves the right to limit benefits to prevent over-utilization or misuse of Prescription Drugs.

VIII. 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 the Contract Administrator or its designated agent, describing the Medical Necessity for the prescription. The Contract Administrator or its designated agent will respond to a request for Prior Authorization received from either the Participants' Physician or the Participant within two (2) business days of the receipt of the medical information necessary to make a determination.

IX. 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 dispensing limitations stated in Item III. of this section.

A. Smoking cessation Prescription Drugs are a Covered Service.

X. Definitions

A. **Allowed Charge**—the amount payable for a Prescription Drug dispensed to a Participant based on the reimbursement formula determined between the Contract Administrator and its PBM plus the dispensing fee for a Prescription Drug dispensed by a retail pharmacy.

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 the Contract Administrator in accordance with the Pharmacy and Therapeutics Committee clinical review. This list is managed and subject to periodic review and amendment by the Contract Administrator and the Pharmacy and Therapeutics Committee. Prescription Drugs covered by the Prescription Drug Benefit are organized into tiers. Generally, lower tiers contain Prescription Drugs that are more Cost Effective and provide a greater value when considering both clinical and financial attributes while higher tiers contain Prescription Drugs that are generally more expensive. Prescription Drugs on lower tiers may include a greater proportion of Preferred and Non-Preferred Generic Drugs while Prescription Drugs on higher tiers may include more Preferred and Non-Preferred Brand Name Drugs and Specialty Prescription Drugs.

ACA Preventive Drugs—ACA Mandated Preventive Drugs, as specifically listed on the Contract Administrator's Formulary on the Contract Administrator's Website, www.bcidaho.com.

Prescribed Contraceptives—Women's Preventive Prescription Drugs and devices as specifically listed on the Contract Administrator's Formulary on the Contract Administrator's Website, www.bcidaho.com. The day supply allowed shall not exceed a ninety (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, cleared or granted contraceptive not included on the Contract Administrator'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, cleared or granted 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 at the telephone number listed on the back of the Participating Employee's Identification Card to obtain the appropriate request form.

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 the Contract Administrator's PBM for the purpose of providing Prescription Drug Covered Services to Participants under the Plan.

H. **Participating Pharmacy/Pharmacist**—a Licensed Pharmacist, a retail, mail order or Specialty Pharmacy that has a contract with the Contract Administrator's PBM for the purpose of providing Prescription Drug Covered Services to Participants.

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

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; and
   g. 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.

XI. Prescription Drug Exclusions and Limitations

If a Participant receives a discount, direct or indirect support, 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.

The Trust 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 Participant's applicable Deductible and/or Out-of-Pocket Limit.

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

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

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

The Contract Administrator will inform the Participant in writing of the reason for rejecting or otherwise refusing to treat a third party payment as a payment from the Participant.

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, through the determination of the Contract Administrator's Pharmacy and Therapeutics Committee, the Contract Administrator may choose to cover certain over-the-counter medications when Prescription Drug benefits are provided under this Benefit Trust Plan. Such approved over-the-counter medications must be identified by the Contract Administrator 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 the Contract Administrator 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.
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, which 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.
    f) Provided by or under the direction of a Home Intravenous Therapy Company, Home Health Agency or other Provider approved by the Contract Administrator. Benefits are available for this Therapy Service under the Medical Benefits Section, and 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.

DEFINITIONS SECTION

For reference, most terms defined in this section are capitalized throughout the Plan. Other terms may be defined where they appear in this Benefit Trust Plan. Definitions in this Benefit Trust 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 the Contract Administrator 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 the Plan.

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

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

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

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

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

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

Amendment (Amend)—a formal document signed by the 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, autism spectrum disorders, or related diagnoses, as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM).

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

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

Benefit Trust Plan—this description of the benefits provided under the Plan.

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

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

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

Board of Trustees—the Board of Trustees of the Idaho 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 the Plan begins within thirty-one (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 the employee incurs as a result of acting on behalf of the Board of Trustees, except if such liability is due to the employee's gross negligence or misconduct.

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

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

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

Chiropractic Physician—an individual licensed to practice chiropractic.

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

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

Clinical Psychologist—an individual licensed to practice clinical psychology.

Congenital Anomaly—a condition existing at or from birth, which is a significant deviation from the common form or function of the body, whether caused by a hereditary or a developmental defect or Disease. In this Benefit Trust 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 (BCI) has been hired as the Contract Administrator by the Board of Trustees to perform claims processing and other specified administrative services in relation to this Benefit Trust Plan. The Contract Administrator is not an insurer of health benefits under this Benefit Trust 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 Benefit Trust Plan.

Contracting Provider—see the Introduction page of the Benefits Outline for the definition of Contracting Provider.

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

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

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

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

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

Covered Service—when rendered by a Provider, a service, supply, or procedure specified in this Benefit Trust 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 the Contract Administrator begins to pay benefits for most Covered Services. The amount credited to the Deductible is based on the Maximum Allowance or the actual charge, whichever is less.

Dentist—an individual licensed to practice Dentistry.

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

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

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

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

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

Domestic Partner—the partner of a Participating Employee with a relationship that demonstrates the following:

1. Partners have executed an Affidavit of Domestic Partnership;
2. Cohabitation in an exclusive mutual commitment similar to that of marriage and have been involved in the domestic partnership for a period of not less than six consecutive months;
3. Neither partner is legally married to any other person nor has another Domestic Partner;
4. Partners are both of the age of consent and are not related by marriage or blood in a way that would otherwise prohibit marriage in the state of their residence;
5. Financial interdependence exists between the Participating Employee and the Domestic Partner as evidenced by at least two of the following documents:
    a) common ownership of real property or a common leasehold in real property;
    b) common ownership of a motor vehicle;
    c) joint bank account or joint credit account; or
    d) designation as a beneficiary for life insurance or retirement benefits.

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 Benefit Trust 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 Benefit Trust 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 the Employer who is entitled to apply as a Participating Employee.

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

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

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

Employer—any Employer participating in the Trust.

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

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

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

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

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

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

Health Benefit Plan—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 care and treatment to be provided to a Participant by a Hospice. The written plan of care must be established and periodically reviewed by the attending Physician.

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

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

Injury—damage to a part of the body caused by trauma from a sudden, unforeseen outside force or object, occurring at an identifiable time and place, and without the Participant's foresight or expectation.

In-Network Services—Covered Services provided by a Contracting Provider or a Contract Administrator approved referral by the Participant's PCP by a Noncontracting Provider.

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

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

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

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

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

In determining whether a technology is investigational, the Contract Administrator considers the following source documents: Blue Cross Blue Shield Association's Evidence Positioning System assessments, the Blue Cross and Blue Shield Association Medical Policy Reference Manual as adopted by the Contract Administrator, and Blue Cross of Idaho Medical Policies. The Contract Administrator also considers current published medical literature and peer review publications based upon scientific evidence, and evidence-based guidelines developed by national organizations and recognized authorities.

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

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

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

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

Licensed Pharmacist—an individual licensed to practice pharmacy.

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

Lifetime Benefit Limit—the greatest aggregate amount payable by the Contract Administrator, 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.

Maximum Allowance—for Covered Services under the terms of the Plan, Maximum Allowance is the lesser of the billed charge or the amount established by the Contract Administrator as the highest level of compensation for a Covered Service. Notwithstanding, if the Contract Administrator has agreed to pay a Contracting Provider an amount for hospital Inpatient or Outpatient services that is higher than the Provider's billed charge, the Maximum Allowance is the allowance set forth in the Provider contract. If the Covered Services are rendered outside the state of Idaho by a Noncontracting or Contracting Provider with a Blue Cross and/or Blue Shield affiliate in the location of the Covered Services, the Maximum Allowance is the lesser of the billed charge or the amount established by the affiliate as compensation.

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

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

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

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

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

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

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

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

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

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

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

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

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 Provider that is not a Contracting Provider under this Connected Care program.

Non-Emergency Preadmission Notification—Non-Emergency Preadmission Notification is a notification to the Contract Administrator by the Participant and is required for all Inpatient admissions except Covered Services subject to Emergency Admission Notification. Non-Emergency Preadmission Notification informs the Contract Administrator, or a delegated entity, of Participant's proposed Inpatient admission to a Licensed General Hospital, Alcohol or Substance Use Disorder Treatment Facility, Psychiatric Hospital, or any other Facility Provider.

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

Occupational Therapist—an individual licensed to practice occupational therapy.

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

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

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

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

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

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

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

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

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

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

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

Plan Date—the date specified in this Benefit Trust 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 the Plan that does not require Prior Authorization before services are rendered.

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

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

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

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

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

Primary Care Physician (PCP)—any duly licensed Physician, who is a Contracting Provider under this managed care program to provide primary care and coordinate Covered Services for Participants and who is willing to accept a panel of patients. A Primary Care Physician includes, general/family practice, pediatrics, internal medicine, obstetric and gynecology (OB-GYN).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Service Area—the specific geographic region where PCPs are located and provide services to Participants. The Service Area for each Participant is determined by the Provider network's geographical area. Please refer to the Provider Directory on the Contract Administrator's Website, www.bcidaho.com, under "Find a Doctor", for Contracting Providers.

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

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

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

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

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

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

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

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

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

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

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

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

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

Therapy Services—Therapy Services include only the following:

1. Radiation Therapy—treatment of Disease by x-ray, radium, or radioactive isotopes.

2. Chemotherapy—treatment of malignant Disease by chemical or biological antineoplastic agents.
3. Renal Dialysis—treatment of an acute or chronic kidney condition, which may include the supportive use of an artificial kidney machine.
4. Physical Therapy—treatment by physical means, hydrotherapy, heat or similar modalities, physical agents, biomechanical and neurophysiological principles, or devices to relieve pain, restore maximum function, or prevent disability following a condition, Disease, Illness, Accidental Injury, or loss of a body part.
5. 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 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 the Contract Administrator.

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

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

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

EXCLUSIONS AND LIMITATIONS SECTION

In addition to the exclusions and limitations listed elsewhere in this Benefit Trust Plan, the following exclusions and limitations apply, 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 are performed by a Contracting Provider and benefits are denied as not Medically Necessary, the cost of said services are not the financial responsibility of the Participant. However, the Participant could be financially responsible for services found to be not Medically Necessary when provided by a Noncontracting Provider.

B. In excess of the Maximum Allowance.

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

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

E. Investigational in nature.

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

G. Provided or paid for by any federal governmental entity or unit except when payment under the Plan is expressly required by federal law, or provided or paid for by any state or local governmental entity or unit where its charges therefore would vary, or are or would be affected by the existence of coverage under this Benefit Trust 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, art, aroma, dance, sex, sleep, electro sleep, vitamin, chelation, homeopathic or naturopathic, massage, or music even if prescribed by a Physician.

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

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

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

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

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

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

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

X. For hearing aids or examinations for the prescription or fitting of hearing aids, except as specified as a Covered Service.

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

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

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

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

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

AD. 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.

AE. For any of the following:

1. For appliances, splints or restorations necessary to increase vertical tooth dimensions or restore the occlusion, except as specified as a Covered Service;
2. For 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;
4. For alveolectomy or alveoloplasty when related to tooth extraction.

AF. For weight control or treatment of 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.

AG. 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.

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

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

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

AK. For acupuncture.

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

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

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

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

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

AQ. 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 Benefit Trust 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 policy of insurance, contract, or underwriting plan.

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

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

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

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

AU. For breast reduction Surgery or Surgery for gynecomastia.

AV. For nutritional supplements.

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

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

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

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

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

AAB. 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.

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

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

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

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

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

AAH For wigs, except as specified as a Covered Service in this Plan.

I. 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. 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.

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

AAN. For the treatment of injuries sustained while operating a motor vehicle under the influence of alcohol and/or narcotics. For purposes of the 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 the 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.

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

AAP. 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.

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

GENERAL PROVISIONS SECTION

I. Termination or Modification of a Participant's Coverage

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 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 Benefit Trust 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 the Contract Administrator (at the Participating Employee's expense) a Physician's certification of such dependent child's incapacity. The Contract Administrator, on behalf of the Trust, may require, at reasonable intervals during the two (2) years following when the child reaches the age limit, subsequent proof of the child's continuing disability and dependency. After two (2) years, the Contract Administrator, on behalf of the Trust, may require such subsequent proof once each year. Coverage for the dependent child will continue so long as the Plan remains in effect, the child's disability and financial dependency exists, and the child has not exhausted benefits.

C. Termination or modification of this Benefit Trust 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 Benefit Trust Plan, and the Trust's notice to the Employer, upon mailing or any other delivery, constitutes complete and conclusive notice to the Participants.

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

E. The Trust may terminate or retroactively rescind a Participant's coverage under this Benefit Trust 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 Benefit Trust 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 Benefit Trust Plan will terminate for an Eligible Dependent on the last day of the month the Participant no longer qualifies as an Eligible Dependent due to a change in eligibility status.

II. COBRA and ERISA Compliance

The Contract Administrator is not the plan administrator for compliance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and any amendments to it; nor is the Contract Administrator the plan administrator for the Employee Retirement Income Security Act (ERISA) and any amendments to it. Except for services the Contract Administrator 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 the Contract Administrator and the Trust—Description of Coverage

This Benefit Trust Plan is part of the Administrative Services Agreement between the Contract Administrator 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 Benefit Trust Plan shall not be construed as a contract between the Contract Administrator or the Trust and any Participating Employee. The Trust's mailing or any electronic delivery of the Plan to the Employer constitutes complete and conclusive issuance and delivery thereof to each Participating Employee.

IV. Benefits to Which Participants are Entitled

A. Subject to all of the terms of this Benefit Trust 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. Benefits will be provided only if Covered Services are prescribed by, or performed by, or under the direction of a Physician or other Professional Provider and are regularly and customarily included in such Providers' charges.

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

D. The 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 the Plan will be provided in writing within sixty (60) days of the Effective Date of change.

V. Notice of Claim

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

VI. Release and Disclosure of Medical Records and Other Information

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

VII. Exclusion of General Damages

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

VIII. Payment of Benefits

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

A. The Contract Administrator, on behalf of the Trust, is authorized by the Participant to make payments directly to Providers rendering Covered Services to the Participant for benefits provided under the Plan. Notwithstanding this authorization, the Contract Administrator, on behalf of the Trust, reserves and shall have the right to make such payments directly to the Participant. Except as provided by law, the Contract Administrator's right, on behalf of the Trust, to pay a Participant directly is not assignable by a Participant nor can it be waived without the Contract Administrator's concurrence, on behalf of the Trust, nor may the right to receive benefits for Covered Services under this Benefit Trust 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. The Contract Administrator and the Trust prohibit direct or indirect payment by third parties unless it meets the standards set below.

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

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

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

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

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

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

IX. Participant/Provider Relationship

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

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

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

X. Participating Plan

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

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

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

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

A. Definitions

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

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

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

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

3. The Order of Benefit Determination Rules determine whether This Contract is a Primary Contract or Secondary Contract when the Participant has health care coverage under more than one (1) Contract. When This Contract is primary, it determines payment for its benefits first before those of any other Contract without considering any other Contract's benefits. When This Contract is secondary, it determines its benefits after those of another Contract and may reduce the benefits it pays so that all Contract benefits do not exceed one hundred percent (100%) of the total Allowable Expense.

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

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

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

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

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

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

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

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

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

B. Order of Benefit Determination Rules

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

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

2. a) Except as provided in Paragraph 2.b) below, a Contract that does not contain a coordination of benefits provision that is consistent with this regulation is always

primary unless the provisions of both Contracts state that the complying Contract is primary.

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

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

4. Each Contract determines its order of benefits using the first of the following rules that apply:

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

b) Dependent Child Covered Under More Than One Contract. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Contract the order of benefits is determined as follows:

(1) For a dependent child whose parents are married or are living together, whether or not they have ever been married: The Contract of the parent whose birthday falls earlier in the calendar year is the Primary Contract; or if both parents have the same birthday, the Contract that has covered the parent the longest is the Primary Contract.

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

i. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Contract of that parent has actual knowledge of those terms, that Contract is primary. This rule applies to Contract year commencing after the Contract is given notice of the court decree;

ii. If a court decree states that both parents are responsible for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (1) shall determine the order of benefits;

iii. If a court decree states both parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage, the provisions of Subparagraph (1) above shall determine the order of benefits;

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

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

4. The Contract covering the spouse of the non-Custodial Parent.

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

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

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

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

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

C. Effect on the Benefits of this Contract

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

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

D. Facility of Payment

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

E. Right of Recovery

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

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

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

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

C. A Participant with end stage renal disease (ESRD) is generally eligible for Medicare starting with the 4th month of dialysis treatments or the month they are admitted to a Medicare-certified hospital for a kidney transplant (or for health care services they will need before the transplant) if the transplant takes place in that same month or within the next two (2) months. A Participant should enroll for Medicare Part A and Part B (or a Medicare Advantage Plan) as soon as possible (but no later than the end of the 30-month coordination period described below), regardless of their age. Detailed information regarding Medicare eligibility and enrollment is available at www.medicare.gov.

If a Participant with ESRD is eligible for coverage under this Benefit Trust Plan as an employee with current employment status or as a spouse or family member of an employee with current employment status, the Plan will continue as the primary coverage for up to 30 months after the earliest date that the Participant is, or could upon filing an application become, entitled to Medicare on the basis of ESRD (this period is referred to as the "30-month coordination period"). Thereafter, the Plan will only pay as the Participant's secondary coverage to the benefits provided by, or the benefits that would have been provided by, Medicare.

Importantly, the Plan will pay secondary to Medicare after the 30-month coordination period regardless of whether the Participant actually enrolls for, pays applicable contribution for, maintains, claims, or receives Medicare benefits. If a Participant fails to enroll for Medicare when first eligible, the Plan will still pay secondary to the benefits that would have been provided by Medicare as if they had enrolled. This could result in the Participant having no coverage for the dialysis treatment or for other services or treatments until they enroll. Without such coverage, a Participant could be personally liable for the full cost of medical services and supplies that Medicare would have paid to facilities and providers if the Participant had enrolled in, or filed an application for benefits under, Medicare.

D. The Employer's retirees, if covered under this Benefit Trust 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 the Plan reduced by any benefits available under Medicare. This applies even if the Participant fails to enroll in Medicare or does not claim the benefits available under Medicare.

XIII. Incorporated by Reference

All of the terms, limitations and exclusions of coverage contained in this Benefit Trust 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.

XIV. Inquiry and Appeals Procedures

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

A. Informal Inquiry

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

B. Formal Appeal

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

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

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

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

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

5. If the original, non-urgent claim decision is upheld upon reconsideration, the Participant may send an additional written appeal to the Appeals and Grievance Coordinator requesting further review. This appeal must set forth the reasons for requesting additional reconsideration and must be sent within thirty (30) days of the Contract Administrator's mailing of the initial reconsideration decision. The Contract Administrator's Medical Director who is not subordinate to the Medical Director or physician designee who decided

the initial appeal will issue a final decision after consideration of all relevant information. A final decision on the appeal will be made within fifteen (15) days of its receipt.

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

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

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

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

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

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

D. Participant's Rights to an Independent External Review

Please read this carefully. It describes a procedure for review of a disputed health claim by a qualified professional who has no affiliation with the Trust or the Contract Administrator. If a Participant or their authorized representative requests an independent external review of a claim, the decision made by the independent reviewer will be binding and final on the Trust. 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 the Contract Administrator, on behalf of the Trust, issues a final Adverse Benefit Determination of a Participant's request to provide or pay for a health care service or supply, a Participant may have the right to have the Contract Administrator's decision reviewed by health care professionals who have no association with the Contract Administrator. A Participant has this right only if the Contract Administrator's denial decision involved:

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

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

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

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

For more information and for an external review request form:

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

A Participant may act as their own representative in a request or a Participant may name another person, including a Participant's treating health care provider, to act as an authorized representative for a request. If a Participant wants someone else to represent them, a Participant must include a signed "Appointment of an Authorized Representative" form with the request before the Contract Administrator, on behalf of the Trust, determines that an individual has been authorized to act on behalf of the Participant. The form can be found on the Contract Administrator's Website, www.bcidaho.com. A Participant's written external review request to the Idaho Department of Insurance must include a completed form authorizing the release of any medical records the independent review organization may require to reach a decision on the external review, 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, the Contract Administrator's final Adverse Benefit Determination will be reviewed by an independent review organization selected by the Department of Insurance. The Trust will pay the costs of the review.

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

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

information in writing to the independent review organization that they want the organization to consider in its review.

5. The independent review organization must provide written notice of its decision to the Participant, the Contract Administrator and to the Department of Insurance within forty-two (42) days after receipt of an external review request.

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

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

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

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

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

Binding Nature of the External Review Decision:
The 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.

XV. Reimbursement of Benefits Paid by Mistake

If the Contract Administrator mistakenly makes payment for benefits on behalf of a Participating Employee or their Eligible Dependent(s) that the Participating Employee or their Eligible Dependent(s) is not entitled to under this Benefit Trust Plan, the Participating Employee must reimburse the erroneous payment to the Contract Administrator, on behalf of the Trust.

The reimbursement is due and payable as soon as the Contract Administrator notifies the Participating Employee and requests reimbursement. The Contract Administrator, on behalf of the Trust, may also recover such erroneous payments from any other person or Provider to whom the payments were made. If

reimbursement is not made in a timely manner, the Contract Administrator, on behalf of the Trust, may reduce benefits or reduce an allowance for benefits as a set-off toward reimbursement.

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

XVI. Subrogation and Reimbursement Rights

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

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

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

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

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

The Participant shall pay the Contract Administrator, on behalf of the Trust as the first priority, and the Contract Administrator shall have a constructive trust and an equitable lien on, all amounts from any recovery by suit, settlement or otherwise from any third party or parties or from any third party's or parties' insurer(s), indemnitor(s) or underwriter(s), to the extent of benefits provided by the Contract Administrator, on behalf of the Trust under this Benefit Trust Plan, regardless of how the recovery is allocated *(i. e.,* pain and suffering) and whether the recovery makes the Participant whole. Thus, the Contract Administrator will be reimbursed by the Participant, or their legal representative, from monies recovered as a result of the injury, harm or loss, for all benefits paid even if the Participant is not made whole or fully compensated by the recovery. Moreover, the Contract Administrator and the Trust are not responsible for any attorney's fees, other expenses or costs

incurred by the Participant without the prior written consent of the Contract Administrator and, therefore, the "common fund" doctrine does not apply to any amounts recovered by any attorney the Participant hires regardless of whether amounts recovered are used to repay benefits paid by the Contract Administrator, on behalf of the Trust.

To the extent that the Contract Administrator, on behalf of the Trust provides or pays benefits for Covered Services, the Contract Administrator 's rights of subrogation and reimbursement extend to any right the Participant has to recover from the Participant's insurer, or under the Participant's "Medical Payments" coverage or any "Uninsured Motorist," "Underinsured Motorist," or other similar coverage provisions, and workers' compensation benefits.

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

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

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

XVII. Statements

In the absence of fraud, all statements made by an applicant, or the Trust, or by an enrolled Participant shall be deemed representations and not warranties, and no statement made for the purpose of acquiring coverage under the Plan shall void such coverage under this Benefit Trust Plan or reduce benefits unless contained in a written instrument signed by the Trust or the Participant.

XVIII. Out-of-Area Services

Overview

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

Typically, when accessing care outside the geographic area the Contract Administrator 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. The Contract Administrator remains responsible for fulfilling its contractual obligations to the Trust. The Contract Administrator payment practices in both instances are described below.

This disclosure describes how claims are administered for Inter-Plan Programs and the fees that are charged in

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

A. BlueCard® Program

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

1. Liability Calculation Method Per Claim – In General

a. Participant Liability Calculation

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

b. The Trust Liability Calculation

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

2. Claims Pricing

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

(i) 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) Average price: 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 below for an estimated price; or

(iii) 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.

The Host Blue will apply the actual, average, or estimated price method consistent with its

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

Any positive or negative differences in average or estimated pricing are accounted for through variance accounts maintained by the Host Blue and are incorporated into future claim prices. As a result, the amounts charged to the Trust will be adjusted in a following year, as necessary, to account for over- or underestimation of the past years' prices. The Host Blue will not receive compensation from how the estimated price or average price methods, described above, are calculated. Because all amounts paid are final, neither positive variance account amounts (funds available to be paid in the following year), nor negative variance amounts (the funds needed to be received in the following year), are due to or from the Trust. If the Trust terminates, you will not receive a refund or charge from the variance account.

Variance account balances are small amounts relative to the overall paid claims amounts and will be liquidated/drawn down over time. The timeframe for their liquidation depends on variables, including, but not limited to, overall volume/number of claims processed and variance account balance. The Trust has no ownership interest in any variance account. Variance accounts are notional bookkeeping accounts maintained by the Host Blue and no amounts are segregated or held for the benefit of the Trust.

3. BlueCard Program Fees and Compensation

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

B. Special Cases: Value-Based Programs

Value-Based Programs Overview

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

Value-Based Programs under the BlueCard Program
Value-Based Programs Administration

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

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

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

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

Provider fee schedule.

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

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

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

The amounts used to calculate either the supplemental factors for estimated pricing or PaMPM billings are fixed amounts that are estimated to be necessary to finance the cost of a particular Value-Based Program. Because amounts are estimates, there may be positive or negative differences based on actual experience, and such differences will be accounted for in a variance account maintained by the Host Blue (in the same manner as described in the BlueCard claim pricing section above) until the end of the applicable Value-Based Program payment and/or reconciliation measurement period. The amounts needed to fund a Value-Based Program may be changed before the end of the measurement period if it is determined that amounts being collected are projected to exceed the amount necessary to fund the program or if they are projected to be insufficient to fund the program.

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

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

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

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

Care Coordination Fees

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

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

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

Value-Based Programs under Negotiated Arrangements

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

For Negotiated Arrangements, when Control/Home Licensees have negotiated with accounts to waive member Cost Sharing for Care Coordinator Fees, the following provision will apply: As part of the Plan, the Contract Administrator and the Trust may agree to waive Participant Cost Sharing for Care Coordination Fees.

C. Prepayment Review and Return of Overpayments

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

Recoveries from a Host Blue or its participating and nonparticipating Providers can arise in several ways, including, but not limited to, antifraud and abuse recoveries, audits/healthcare Provider/hospital bill audits, credit balance audits, utilization review refunds and unsolicited refunds. Recoveries will be applied so that corrections will be made, in general, on either a claim-by-claim or prospective basis. If recovery amounts are passed on a claim-by-claim basis from a Host Blue to the Contract Administrator they will be credited to the Trust account. When a Host Blue identifies and collects these recovery amounts, the Host Blue may bill the Contract Administrator up to a maximum of 16 percent of the savings identified, unless an alternative reimbursement arrangement is agreed upon by the Contract Administrator and the Host Blue, and these fees may be charged to the Trust. In some cases, the Host Blue will engage a third party to assist in identification or collection of recovery amounts. When this occurs, the Host Blue may bill the lesser of the full amount of the third-party fees or up to 16 percent of the savings identified, unless an alternative reimbursement arrangement is agreed upon by the Contract Administrator and the Host Blue, and these fees may be charged to the Trust.

Unless otherwise agreed to by the Host Blue, for retroactive cancellations of membership, the Contract Administrator will request the Host Blue to provide full refunds from participating healthcare Providers for a period of only one year after the date of the Inter-Plan financial settlement process for the original claim. 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, and Care Coordination Fees or (c) would jeopardize the Host Blue's relationship with its participating healthcare Providers, notwithstanding any conflicting provision found elsewhere in the Plan.

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

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

E. Nonparticipating Providers Outside the Contract Administrator's Service Area

Please refer to the Out-of-Area Care section in this Benefit Trust Plan.

F. Blue Cross Blue Shield Global® Core

1. General Information

If Participants are outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands (hereinafter: "BlueCard service area"), they may be able to take advantage of Blue Cross Blue Shield Global Core when accessing Covered Services. Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although Blue Cross Blue Shield S 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 service center for assistance, hospitals will not require Participants to pay for covered Inpatient services, except for their Cost Sharing amounts/Deductibles, etc. In such cases, the hospital will submit Participant claims to the 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 Blue Cross Blue Shield 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 Blue Cross Blue Shield Global Core claim form and send the claim form with the Provider's itemized bill(s) to the service center address on the form to initiate claims processing. The claim form is available from Blue Cross of Idaho, the service center, or online at www.bcbsglobalcore.com. If Participants need assistance with their claim submissions, they should call the 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. Blue Cross Blue Shield Global Core-Related Fees

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

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

Modifications or changes to Inter-Plan Programs fees are generally made effective Jan. 1 of the calendar year, but they may occur at any time during the year. In the case of any such modifications or changes, the Contract Administrator shall provide the Trust with at least thirty (30) days' advance written notice of any modification or change to such Inter-Plan Programs fees or compensation describing the change and the effective date thereof and the Trust right to terminate this Agreement

without penalty by giving written notice of termination before the effective date of the change. If the Trust fails to respond to the notice and does not terminate this Agreement during the notice period, the Trust will be deemed to have approved the proposed changes, and the Contract Administrator will then allow such modifications to become part of this Agreement.

XIX. Coverage and Benefits Determination

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

XX. Health Care Providers Outside the United States

The benefits available under the Plan are also available to Participants traveling or living outside the United States. The Inpatient Notification and Prior Authorization requirements will apply. If the Provider is a Contracting Provider with BlueCard, the Contracting Provider will submit claims for reimbursement on behalf of the Participant. Reimbursement for Covered Services will be made directly to the Contracting Provider. If the Health Care Provider does not participate with BlueCard, the Participant will be responsible for payment of services and submitting a claim for reimbursement to the Contract Administrator. The Contract Administrator will require the original claim along with an English translation. It is the Participant's responsibility to provide this information.

The Contract Administrator 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 Benefit Trust Plan.

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RIGHTS OF PLAN PARTICIPANTS

As a participant in the Idaho AGC Self-Funded Benefit Trust 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 thirty (30) days, you may file suit in a federal court. The court may require the Trust to provide the materials and pay you up to $110 a day until you receive the materials unless the delay is beyond the control of the Trust. If the people who operate the Plan misuse the Plan's money, or if you are discriminated against for enforcing your rights you may seek assistance from the U.S. Department of Labor or file suit in a federal court. If you do file suit, the court will decide who should pay court costs and legal fees. If your case is upheld by the court, the court may order the person or organization you have sued to pay related expenses. If you lose or the court finds your case frivolous, you may be ordered to pay the court costs and legal fees.

If you have a question about this statement or about your rights under 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.