SUMMARY PLAN DESCRIPTION FOR:

CITY OF CHUBBUCK HEALTH PLAN TRUST

Sponsored by the City of Chubbuck

Claims Administered by Regence BlueShield of Idaho, Inc.
Group Number: 100299952

This is a self-funded health plan. The plan is not insurance and does not participate in the Idaho life and health guaranty association.

Introduction

Welcome to participation in the self-funded group health plan (hereafter referred to as "The Plan") provided for You by Your employer.

This Summary Plan Description defines who is covered, when and under what circumstances, what expenses are covered, and how claims are submitted.

The City of Chubbuck (the Plan Sponsor) sponsors the City of Chubbuck Health Plan Trust (The Trust). The Trust, administered by Trustees, funds claims. The Trust has chosen Regence BlueShield of Idaho, Inc. (the Claims Administrator) to administer claims for The Plan. The Claims Administrator (Regence BlueShield of Idaho, Inc.) pays medical benefits to active employees and their eligible dependents. These medical benefits are not paid through an insurance policy. This health plan is not insurance and is not subject to the Idaho Guaranty association. Rather, claims are funded by the Trust which is funded by contributions from the City of Chubbuck. The Trust funds claims up to a certain limit and then has an agreement for stop-loss coverage that funds claims that exceed that limit. The Idaho Department of Insurance requires the Trust to provide an annual audit and to have an independent accredited actuary provide annual certification of the funding amounts and the contributions.

Throughout this Summary Plan Description, Your employer may be referred to as the "Plan Sponsor." The City of Chubbuck Health Plan Trust may be referred to as “the Trust” or “Trustee(s).” Regence BlueShield of Idaho, Inc. is referred to as the “Claims Administrator.”

EMPLOYER PAID BENEFITS

The Plan is an employer-paid benefits plan administered by the Trust. Because of their extensive experience and reputation of service, Regence BlueShield of Idaho, Inc. has been chosen by the Trust as the Claims Administrator for the Plan. The Claims Administrator provides administrative claims payment services only. This means that Your employer, through the City of Chubbuck Health Plan Trust and not Regence BlueShield of Idaho, Inc., funds covered medical services and supplies. You participate in claims payments by paying a Deductible and Cost Sharing up to the Out of Pocket Limit. Your claims will be paid only after Your employer through the Trust provides Regence BlueShield of Idaho, Inc. with the funds to pay Your benefits and pay all other charges due under the Plan.

The following pages are the Summary Plan Description, the written description of the terms and benefits of coverage available under the Plan. This Summary Plan Description describes benefits effective **October 01**, **2019**, or the date after that on which Your coverage became effective. This Summary Plan Description replaces any plan description, Summary Plan Description or certificate previously issued by Regence BlueShield of Idaho, Inc. and makes it void.

As You read this Summary Plan Description, please keep in mind that references to "You" and "Your" refer to both the Participant and Beneficiaries (except that in the Who Is Eligible, How To Enroll and When Coverage Begins, When Coverage Ends, COBRA Continuation and Other Continuation Options (if applicable) sections, the terms "You" and "Your" mean the Participant only). The term "Agreement" refers to the administrative services contract between the City of Chubbuck Health Plan Trust and the Claims Administrator. Other terms are defined in the Definitions Section at the back of this Summary Plan Description or where they are first used.

This employee benefit plan is not governed by the Employee Retirement Income Security Act (ERISA). Throughout the Summary Plan Description, references to "ERISA" do not apply to the Plan which is not part of an employee welfare benefit plan regulated under ERISA.

Federal law mandates coverage for certain breast reconstruction services in connection with a covered mastectomy. See Women's Health and Cancer Rights in the General Provisions Section in this Summary Plan Description for details.

Statement of Rights Under the Newborns' and Mothers' Health Protection Act: Under federal law, group health plans generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending Provider (for example, Your Physician, nurse midwife, or Physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

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

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

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

CONTACT INFORMATION
Customer Service: 1 (866) 240-9580 (TTY: 711)
And visit the Claims Administrator's Web site at: **www.Regence.com**
For assistance in a language other than English please call the Customer Service telephone number.

Using Your Summary Plan Description

YOUR PARTNER IN HEALTH CARE
The selected Claims Administrator for the Plan, Regence BlueShield of Idaho, Inc., provides You with great benefits that are quickly accessible and easy to understand, thanks to open access to Providers and innovative tools. With these tools, You will discover the personal freedom to make informed health care decisions, as well as the assistance You need to navigate the health care system.

YOU SELECT YOUR PROVIDER AND CONTROL YOUR OUT-OF-POCKET EXPENSES
The Plan allows You to control Your out-of-pocket expenses, such as Deductibles and Cost-sharing, for each Covered Service. Here's how it works - You control Your out-of-pocket expenses by choosing Your Provider under two choices called: "In-Network" and "Out-of-Network."

- **In-Network.** You choose to see an In-Network Provider and save the most in Your out-of-pocket expenses. Choosing this provider option means You will not be billed for balances beyond any Deductible and/or Cost Sharing for Covered Services.

- **Out-of-Network.** You choose to see an Out-of-Network Provider that does not have a participating contract with the Claims Administrator and Your out-of-pocket expenses will generally be higher than seeing an In-Network Provider. Also, choosing this provider option means You may be billed for balances beyond any Deductible and/or Cost Sharing. This is sometimes referred to as balance billing.

For each benefit in this Summary Plan Description, the Provider You may choose and Your payment amount for each provider option is indicated. See the Definitions Section in this Summary Plan Description for a complete description of In-Network and Out-of-Network. You can go to **www.Regence.com** for further Provider network information.

ADDITIONAL PARTICIPATION ADVANTAGES

The Plan offers You access to valuable services. The advantages of Regence BlueShield of Idaho, Inc. involvement as the Claims Administrator include access to personalized health care planning information, health-related events and innovative health-decision tools, as well as a team dedicated to Your personal health care needs. You also have access to **www.Regence.com**, an interactive environment that can help You navigate Your way through health care decisions. **THESE ADDITIONAL VALUABLE SERVICES ARE PROVIDED BY THE CLAIMS ADMINISTRATOR.**

- **Go to www. Regence.com.** It is a health power source that can help You lead a healthy lifestyle, become a well-informed health care shopper and increase the value of Your health care dollar. Have The Plan identification card handy to log on. Use the secure Web site to:

  - view recent claims, benefits and coverage;
  - find a contracting Provider;
  - participate in online wellness programs and use tools to estimate upcoming healthcare costs;
  - identify Participating Pharmacies;
  - find alternatives to expensive medicines;
  - learn about prescriptions for various Illnesses;
  - and compare medications based upon performance and cost, as well as discover how to receive discounts on prescriptions.

GUIDANCE AND SERVICE ALONG THE WAY

This Summary Plan Description was designed to provide information and answers quickly and easily. Be sure to understand Your benefits before You need them. You can learn more about the unique advantages of Your health care coverage throughout this Summary Plan Description, some of which are highlighted here. If You have questions about Your health care coverage, please contact the Claims Administrator.

- **Learn more and receive answers about Your coverage.** Just call 1 (866) 240-9580 to talk with one of the Claims Administrator's Customer Service representatives. Phone lines are open Monday-Friday 6 a.m. - 6 p.m. You may also visit the Claims Administrator's Web site at: **www.Regence.com**.
- **Case Management.** You can request that a case manager be assigned or You may be assigned a case manager to help You and Your Physician best use Your benefits and navigate the health care system in the best way possible. Case managers assess Your needs, develop plans, coordinate resources and negotiate with Providers. Call Case Management at 1 (866) 543-5765.
- **BlueCard® Program.** Learn how to have access to care through the BlueCard Program. This unique program enables You to access Hospitals and Physicians when traveling outside the four-state area

Regence BlueShield of Idaho, Inc. serves (Idaho, Oregon, Utah and Washington), as well as receive care in 200 countries around the world.

DISCRIMINATION IS AGAINST THE LAW

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

Regence BlueShield of Idaho, Inc.:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact 888-344-6347.

If you believe that Regence BlueShield of Idaho, Inc. has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our civil rights coordinator at M/S CS B32B, P.O. Box 1271, Portland, OR 97207-1271, phone: 888-344-6347, TTY: 711, email: CS@regence.com. Please indicate you wish to file a civil rights grievance. 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 http://www.hhs.gov/ocr/office/file/index.html.

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Understanding Your Benefits

In this section, You will discover information to help You understand what is meant by Your Maximum Benefits, Deductibles, Cost Sharing and Out-of-Pocket Maximum. Other terms are defined in the Definitions Section at the back of this Summary Plan Description or where they are first used and are designated by the first letter being capitalized.

While this Understanding Your Benefits Section defines these types of cost-sharing elements, You need to refer to the Medical Benefits Section to see exactly how they are applied and to which benefits they apply.

MAXIMUM BENEFITS
Some benefits for Covered Services may have a specific Maximum Benefit. For those Covered Services, benefits will be provided until the specified Maximum Benefit (which may be a number of days, visits, services, supplies, dollar amount or specified time period) has been reached. Allowed Amounts for Covered Services provided are also applied toward the Deductible and against any specific Maximum Benefit that is expressed in this Summary Plan Description as a number of days, visits, services or supplies. Refer to the Medical Benefits Section in this Summary Plan Description to determine if a Covered Service has a specific Maximum Benefit.

OUT-OF-POCKET MAXIMUM
An important feature of this high deductible health Plan is how the single and Family Out-of-Pocket Maximums work. The key is understanding the difference between "single" and "family" coverage. Single Coverage means only one person has coverage under the Plan. An employee who is the only one in his or her Family who has coverage under the Plan, a husband and wife who both work for the Plan Sponsor and have each filled out an application and are Participants on separate coverages, and a Beneficiary who is continuing coverage on his or her own are all examples of Single Coverage. Family Coverage, on the other hand, means two or more members of the same Family have coverage under the Plan under a single application.

Claimants can meet the Out-of-Pocket Maximum by payments of Deductible and Cost Sharing for all categories as specifically indicated in the Medical Benefits Section. Any amounts You pay for non-Covered Services or amounts in excess of the Allowed Amount do not apply toward the Out-of-Pocket Maximum. You will continue to be responsible for amounts that do not apply toward the Out-of-Pocket Maximum, even after You reach this Plan's Out-of-Pocket Maximum.

Once You reach the Out-of-Pocket Maximum, benefits will be paid at 100 percent of the Allowed Amount for the remainder of the Calendar Year.

The Family Out-of-Pocket Maximum for a Calendar Year is satisfied when some or all Family members' Deductibles and Cost Sharing for Covered Services for that Calendar Year total and meet the Family Out-of-Pocket Maximum amount.

PERCENTAGE PAID UNDER THE PLAN (COST SHARING)
Once You have satisfied any applicable Deductible, the Plan pays a percentage of the Allowed Amount for Covered Services You receive, up to any Maximum Benefit. When payment is less than 100 percent,

You pay the remaining percentage (this is Your Cost Sharing amount). Your Cost Sharing will be based upon the lesser of the billed charges or the Allowed Amount. The percentage the Plan pays varies, depending on the kind of service or supply You received and who rendered it.

The Plan does not reimburse Providers for charges above the Allowed Amount. However, an In-Network Provider will not charge You for any balances for Covered Services beyond Your Deductible and/or Cost Sharing amount. Out-of-Network Providers, however, may bill You for any balances over the Plan payment level in addition to any Deductible and/or Cost Sharing amount. See the Definitions Section for descriptions of Providers.

DEDUCTIBLES
The Plan will begin to pay benefits for Covered Services in any Calendar Year only after a Claimant satisfies the Calendar Year Deductible. A Claimant who is enrolled on Single Coverage satisfies the Single Coverage Deductible by incurring a specific amount of expense for Covered Services during the Calendar Year for which the Allowed Amounts total and meet the Single Coverage Deductible.

The Family Coverage Deductible is satisfied when some or all covered Family members' Allowed Amounts for Covered Services for that Calendar Year total and meet the Family Coverage Deductible amount. However, no one Claimant will be required to meet more than the Single Coverage Deductible amount toward the Family Coverage Deductible in a Calendar Year.

The Plan does not pay for services applied toward the Deductible. Refer to the Medical Benefits Section to see if a particular service is subject to the Deductible. Any amounts You pay for non-Covered Services or amounts in excess of the Allowed Amount do not count toward the Deductible.

HOW CALENDAR YEAR BENEFITS RENEW
Many provisions in this Plan (for example, Deductibles, Out-of-Pocket Maximum, and certain benefit maximums) are calculated on a Calendar Year basis. Each January 1, those Calendar Year maximums begin again.
Some benefits in this Plan have a separate Maximum Benefit based upon a Claimant's Lifetime and do not renew every Calendar Year. Those exceptions are specifically noted in the benefits sections in this Summary Plan Description.

Medical Benefits

In this section, You will learn about Your health plan's benefits and how Your coverage pays for Covered Services. There are no referrals required before You can use any of the benefits of this coverage, including women's health care services. For Your ease in finding the information regarding benefits most important to You, these benefits have been listed alphabetically, with the exception of the Preventive Care and Immunizations and Professional Services benefits.

All covered benefits are subject to the limitations, exclusions and provisions of this Plan. To be covered, medical services and supplies must be Medically Necessary for the treatment of an Illness or Injury (except for any covered preventive care). Also, a Provider practicing within the scope of his or her license must render the service. Please see the Definitions Section in the back of this Summary Plan

Description for descriptions of Medically Necessary and of the kinds of Providers who deliver Covered Services.

A Health Intervention may be medically indicated or otherwise be Medically Necessary, yet not be a Covered Service under the Plan.

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

CALENDAR YEAR OUT-OF-POCKET MAXIMUM

The maximum Out-of-Pocket for any Claimant on Family Coverage is not to exceed $5,000, including any Deductible. If a Claimant reaches this maximum amount prior to satisfying the Family Out-of-Pocket Maximum, including any Deductible, benefits will be paid at 100 percent of the Allowed Amount for that Claimant.
Single Coverage: $5,000
Family Coverage: $10,000

Be aware that Your actual costs for Covered Services provided by an Out-of-Network Provider may exceed this Summary Plan Description's Out-of-Pocket Maximum amount. Also, Out-of-Network Providers can bill You for the difference between the amount charged and the Plan's Allowed Amount and that amount does not count toward any Out-of-Pocket Maximum.

COST SHARING

Cost Sharing is the portion of covered claims paid by the employee. Cost sharing is listed in the tables for Covered Services for each applicable benefit.

CALENDAR YEAR DEDUCTIBLES

Single Coverage Deductible: $3,000
Family Coverage Deductible: $7,000; however, no one Family member will be required to meet more than the Single Coverage Deductible amount.

You do not need to meet any Deductible before receiving benefits for:

- Preventive Care and Immunizations.

Furthermore, You do not need to meet any Deductible before receiving In-Network benefits for Preventive Care and Immunizations. You do not need to meet any Deductible when You fill prescriptions for those Generic Medications or Formulary Brand-Name Medications specifically designated as preventive for treatment of certain chronic diseases that are on the Optimum Value Medication List found at **www.Regence.com** or by calling the Claims Administrator's Customer Service at 1 (866) 240-9580.

PREVENTIVE CARE AND IMMUNIZATIONS

Benefits will be covered under this Preventive Care and Immunizations benefit, not any other provision in this Summary Plan Description, if services are in accordance with age limits and frequency guidelines according to, and as recommended by, the United States Preventive Service Task Force (USPSTF), the Health Resources and Services Administration (HRSA), or by the Advisory Committee on Immunization

Practices of the Centers for Disease Control and Prevention (CDC). In the event any of these bodies adopts a new or revised recommendation, this Plan has up to one year before coverage of the related services must be available and effective under this benefit. For a list of services covered under this benefit, please visit **www.Regence.com** or contact Customer Service at 1 (866) 240-9580. NOTE: Covered Services that do not meet these criteria will be covered the same as any other Illness or Injury.

In addition to Covered Services for Preventive Care and Immunizations by an In-Network Provider, Covered Services for Preventive Care and Immunizations provided by a Provider that has any form of participating contract to provide services and supplies to Claimants in accordance with the provisions of this Plan, will be covered as an In-Network benefit as explained below.

Preventive Care

Provider: In-Network	**Provider: Out-of-Network**
Payment: The Plan pays 100% of the Allowed Amount.	**Payment:** The Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

The Plan covers preventive care services provided by a professional Provider or facility. Preventive care services include routine well-baby care, routine physical examinations, routine well-women's care, routine immunizations and routine health screenings. Also included is Provider counseling for tobacco use cessation and Generic Medications prescribed for tobacco use cessation. See the Prescription Medications benefit in this Summary Plan Description for a description of how to obtain Generic Medications. Coverage for all such services is provided only for preventive care as designated above (which designation may be modified from time to time).

The Plan covers one non-Hospital grade breast pump (including its accompanying supplies) per pregnancy at the In-Network benefit level when obtained from a Provider (including a Durable Medical Equipment supplier). Alternatively, a comparable breast pump may be obtained from approved non-Providers in lieu of a Provider. Benefits for a comparable breast pump obtained from an approved non-Provider will be covered up to the In-Network benefit level and In-Network Allowed Amount. An approved non-Provider may include, but is not limited to, retailers, wholesalers or commercial vendors. To find an approved non-Provider, instructions for claiming benefits or for additional information on Covered Services, please visit the Claims Administrator's Web site at **www.Regence.com** or contact Customer Service at 1 (866) 240-9580.

Additionally, the Plan covers all United States Food and Drug Administration (FDA) approved contraceptive and sterilization methods for women in accordance with HRSA recommendations. These include female condoms, diaphragm with spermicide, sponge with spermicide, cervical cap with spermicide, spermicide, oral contraceptives (combined pill, mini pill, and extended/continuous use pill), contraceptive patch, vaginal ring, contraceptive shot/injection, emergency contraceptives (both levonorgestrel- and ulipristal acetate-containing products), intrauterine devices (both copper and those with progestin), implantable contraceptive rod, surgical implants and surgical sterilization. Please visit the Claims Administrator's Web site at **www.Regence.com** for the preferred contraceptive products covered under the Prescription Medications benefit.

Immunizations – Adult and Childhood

Provider: In-Network
Payment: The Plan pays 100% of the Allowed Amount.

Provider: Out-of-Network
Payment: The Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

The Plan covers immunizations for adults and children according to, and as recommended by, the USPSTF and the CDC. Covered expenses do not include immunizations if the Claimant receives them only for purposes of travel, occupation or residence in a foreign country.

PROFESSIONAL SERVICES

Provider: In-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.

Provider: Out-of-Network
Payment: After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of Maximum. Allowed Amount will be applied toward the Out-of-Pocket Maximum.

The Plan covers services and supplies provided by a professional Provider subject to any Deductible and Cost Sharing and any specified limits as explained in the following paragraphs:

Medical Services
The Plan covers professional services, second opinions and supplies, including the services of a Provider whose opinion or advice is requested by the attending Provider, that are generally recognized and accepted non-surgical procedures for diagnostic or therapeutic purposes in the treatment of Illness or Injury. Services and supplies also include those to treat a Congenital Anomaly for Claimants up to age 26 and foot care associated with diabetes.

Office Visits
The Plan covers office visits for treatment of Illness or Injury.

Professional Inpatient
The Plan covers professional inpatient visits for Illness or Injury. If pre-arranged procedures are performed by an In-Network Provider and You are admitted to an In-Network Hospital, the Plan will cover associated services (for example, anesthesiologist, radiologist, pathologist, surgical assistant, etc.) provided by In-Network and Out-of-Network Providers at the In-Network benefit level. However, an Out-of- Network Provider may bill You for balances beyond any Deductible and/or Cost Sharing. Please contact the Claims Administrator's Customer Service for further information and guidance.

Radiology and Laboratory
The Plan covers diagnostic services for treatment of Illness or Injury. This includes, but is not limited to, mammography services not covered under the Preventive Care and Immunizations benefit.

Diagnostic Procedures
The Plan covers services for diagnostic procedures including cardiovascular testing, colonoscopies, pulmonary function studies, stress tests, sleep studies and neurology/neuromuscular procedures.

Surgical Services
The Plan covers surgical services and supplies including the services of a surgeon, an assistant surgeon and an anesthesiologist.

Therapeutic Injections
The Plan covers therapeutic injections and related supplies when given in a professional Provider's office.

A selected list of Self-Administrable Injectable Medications is covered under the Prescription Medications benefit in this Summary Plan Description. Teaching doses (by which a Provider educates the Claimant to self-inject) are covered for this list of Self-Administrable Injectable Medications up to a limit of three doses per medication per Claimant Lifetime. Teaching doses that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services.

AMBULANCE SERVICES

Provider: All
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

The Plan covers ambulance services to the nearest Hospital equipped to provide treatment, when any other form of transportation would endanger Your health and the purpose of the transportation is not for personal or convenience purposes. Covered ambulance services include licensed ground and air ambulance Providers.

AMBULATORY SURGICAL CENTER

Provider: In-Network
Payment: After Deductible, the Plan pays 90% and You pay 10% of the Allowed Amount. Your 10% payment will be applied toward the Out-of-Pocket Maximum.

Provider: Out-of-Network
Payment: After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

The Plan covers outpatient services and supplies of an Ambulatory Surgical Center for Injury and Illness (including services of staff Providers).

APPROVED CLINICAL TRIALS

The Plan covers Your Routine Patient Costs in connection with an Approved Clinical Trial in which You are enrolled and participating subject to any Deductible, Cost Sharing and Maximum Benefits as specified in the Medical Benefits and Prescription Medications benefits in this Summary Plan Description. Additional specified limits are as further defined. If an In-Network Provider is participating in the Approved Clinical Trial and will accept You as a trial participant, these benefits will be provided only if You participate in the Approved Clinical Trial through that Provider. If the Approved Clinical Trial is conducted outside Your state of residence, You may participate and benefits will be provided in accordance with the terms for other covered out-of-state care.

Definitions
In addition to the definitions in the Definitions Section, the following definitions apply to this Approved

Clinical Trials benefit:

Approved Clinical Trial means a phase I, phase II, phase III or phase IV clinical trial conducted in relation to prevention, detection or treatment of cancer or other Life-threatening Condition and that is a study or investigation:

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

- Conducted under an investigational new drug application reviewed by the Food and Drug Administration or that is a drug trial exempt from having an investigational new drug application.

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

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

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

BLOOD BANK

Provider: All
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

The Plan covers the services and supplies of a blood bank, excluding storage costs.

DENTAL HOSPITALIZATION

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

The Plan covers inpatient and outpatient services and supplies for hospitalization for Dental Services (including anesthesia), if hospitalization in an Ambulatory Surgical Center or Hospital is necessary to safeguard Your health.

DETOXIFICATION

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 80% of the Allowed Amount and You pay balance of billed charges. Your 20% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

The Plan covers Medically Necessary detoxification.

DIABETES SUPPLIES AND EQUIPMENT

The Plan covers supplies and equipment for the treatment of diabetes. Please refer to the Professional Services, Diabetic Education, Durable Medical Equipment, Nutritional Counseling, Orthotic Devices or Prescription Medications benefits in this Summary Plan Description for coverage details of such covered supplies and equipment.

DIABETIC EDUCATION

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

The Plan covers services and supplies for diabetic self-management training and education. Nutritional therapy is covered under the Nutritional Counseling benefit.

DURABLE MEDICAL EQUIPMENT

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

Durable Medical Equipment means an item that can withstand repeated use, is primarily used to serve a medical purpose, is generally not useful to a person in the absence of Illness or Injury and is appropriate for use in the Claimant's home. Examples include oxygen equipment and wheelchairs. Durable Medical Equipment is not covered if it serves solely as a comfort or convenience item.

Alternatively, the Plan covers Durable Medical Equipment up to the In-Network benefit level and In-Network Allowed Amount when obtained from an approved non-Provider. An approved non-Provider may include, but is not limited to, retailers, wholesalers or commercial vendors. To verify eligible Durable Medical Equipment, find an approved non-Provider, instructions for claiming benefits or for additional information on Covered Services, please visit the Claims Administrator's Web site at **www.Regence.com** or contact Customer Service at 1 (866) 240-9580.

EMERGENCY ROOM (INCLUDING PROFESSIONAL CHARGES)

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 80% of the Allowed Amount and You pay balance of billed charges. Your 20% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

The Plan covers emergency room services and supplies, including outpatient charges for patient observation and medical screening exams that are required for the stabilization of a patient experiencing an Emergency Medical Condition. For the purpose of this benefit, "stabilization" means to provide Medically Necessary treatment: 1) to assure, within reasonable medical probability, no material deterioration of an Emergency Medical Condition is likely to occur during, or to result from, the transfer of the Claimant from a facility; and 2) in the case of a covered female Claimant, who is pregnant, to perform the delivery (including the placenta). Emergency room services do not need to be pre-authorized. If admitted to an Out-of-Network Hospital directly from the emergency room, services will be covered at the In-Network benefit level. However, an Out-of-Network Provider may bill You for balances beyond any Deductible and/or Cost Sharing. Please contact the Claims Administrator's Customer Service for further information and guidance. See the Hospital Care benefit in this Medical Benefits Section for coverage of inpatient Hospital admissions.

FAMILY PLANNING

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

The Plan covers certain professional Provider contraceptive services and supplies, including, but not limited to, vasectomy. See the Prescription Medications benefits for coverage of prescription contraceptives.

Please see the Preventive Care and Immunizations benefit for coverage of women's contraceptive methods, sterilization procedures and patient education and counseling services in accordance with any frequency guidelines according to, and as recommended by HRSA.

GENETIC TESTING

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

HOME HEALTH CARE

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.
Limit: 130 visits per Claimant per Calendar Year	

The Plan covers home health care when provided by a licensed agency or facility for home health care. Home health care includes all services for patients that would be covered if the patient were in a Hospital or Skilled Nursing Facility. Home health care visits that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services. Durable Medical Equipment associated with home health care services is covered under the Durable Medical Equipment benefit in this Summary Plan Description.

HOSPICE CARE

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.
Limit: 14 inpatient or outpatient respite care days per Claimant Lifetime	

The Plan covers hospice care when provided by a licensed hospice care program. A hospice care program is a coordinated program of home and inpatient care, available 24 hours a day. This program uses an interdisciplinary team of personnel to provide comfort and supportive services to a patient and any family members who are caring for a patient, who is experiencing a life threatening disease with a limited prognosis. These services include acute, respite and home care to meet the physical, psychosocial and special needs of a patient and his or her family during the final stages of Illness. Respite care: The Plan covers respite care to provide continuous care of the Claimant and allow temporary relief to family members from the duties of caring for the Claimant. Respite days that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services. Durable Medical Equipment associated with hospice care is covered under the Durable Medical Equipment benefit in this Summary Plan Description.

HOSPITAL CARE – INPATIENT AND OUTPATIENT

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

The Plan covers the inpatient and outpatient services and supplies of a Hospital for Injury and Illness (including services of staff Providers billed by the Hospital). Room and board is limited to the Hospital's average semiprivate room rate, except where a private room is determined to be necessary. See the Emergency Room benefit in this Medical Benefits Section for coverage of emergency services, including medical screening exams, in a Hospital's emergency room.

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

MATERNITY CARE

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

The Plan covers prenatal and postnatal maternity (pregnancy) care, childbirth (vaginal or cesarean), involuntary complications of pregnancy, and related conditions for a female Participant, a female Enrolled Spouse or female domestic partner. The Plan covers involuntary complications of pregnancy for a female Enrolled Child only as specified below. There is no limit for the mother's length of inpatient stay. Where the mother is attended by a Provider, the attending Provider will determine an appropriate discharge time, in consultation with the mother. See the Newborn Care benefit in this Summary Plan Description to see how the care of Your newborn is covered. Coverage also includes termination of pregnancy only when done to preserve the life of the female Claimant.

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

The Plan will cover a female Claimant for involuntary complications of pregnancy including:

- ectopic pregnancy which is terminated;
- spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible;
- puerperal infection;
- eclampsia;
- toxemia; and
- conditions requiring inpatient confinement (when the pregnancy is not terminated), the diagnoses of which are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity.

Additionally, the Plan will only cover a female Participant, a female Enrolled Spouse or female domestic partner for the following involuntary complication of pregnancy:

- cesarean section delivery.

Involuntary complications of pregnancy do not include:

- false labor;
- occasional spotting;
- Physician-prescribed bed rest during the period of 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.

Definitions

In addition to the definitions in the Definitions Section, the following definitions apply to this Maternity Care benefit:

Enrolled Spouse: means a Beneficiary who is the Participant's spouse.

Enrolled Child: means a Beneficiary who is the Participant's child.

MEDICAL FOODS (PKU)

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

The Plan covers medical foods for inborn errors of metabolism including, but not limited to, formulas for Phenylketonuria (PKU).

MENTAL HEALTH OR SUBSTANCE USE DISORDER SERVICES

In addition to Covered Services for Mental Health or Substance Use Disorders by an In-Network Provider, Covered Services for Mental Health or Substance Use Disorders provided by a Provider that has any form of participating contract to provide services and supplies to Claimants in accordance with the provisions of this Plan, will be covered as an In-Network benefit as explained below.

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

The Plan covers Mental Health and Substance Use Disorder Services for treatment of Mental Health Conditions or Substance Use Disorders.

Definitions

In addition to the definitions in the Definitions Section, the following definitions apply to this Mental Health or Substance Use Disorder Services benefit:

Mental Health or Substance Use Disorder Services mean Medically Necessary outpatient services, Residential Care, partial Hospital program or inpatient services provided by a licensed facility or licensed individuals with the exception of Skilled Nursing Facility services (unless the services are provided by a licensed behavioral health provider for a covered diagnosis), home health services and court ordered treatment (unless the treatment is determined to be Medically Necessary).

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

Residential Care means care received in an organized program which is provided by a residential facility, Hospital, or other facility licensed, for the particular level of care for which reimbursement is being sought, by the state in which the treatment is provided.

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

NEURODEVELOPMENTAL THERAPY

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.
Inpatient limit: unlimited **Outpatient limit:** 28 visits per Claimant per Calendar Year for all outpatient neurodevelopmental therapy services	

The Plan covers inpatient and outpatient neurodevelopmental therapy services. To be covered, such services must be to restore or improve function for a Claimant age six and under with a neurodevelopmental delay. For the purpose of this benefit, "neurodevelopmental delay" means a delay in normal development that is not related to any documented Illness or Injury. Covered Services include only physical therapy, occupational therapy and speech therapy and maintenance services, if significant deterioration of the Claimant's condition would result without the service. You will not be eligible for both the Rehabilitative Services benefit and this benefit for the same services for the same condition. Outpatient neurodevelopmental therapy visits that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services.

NEWBORN CARE

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

The Plan covers services and supplies, under the newborn's own coverage, in connection with nursery care for the natural newborn or newly adoptive child. The Newborn Child must be eligible and enrolled as explained later in the Who Is Eligible, How to Enroll and When Coverage Begins Section. There is no limit for the newborn's length of inpatient stay. For the purpose of this benefit, "newborn care" means the medical services provided to a Newborn Child following birth including well-baby Hospital nursery charges, the initial physical examination and a PKU test.

NUTRITIONAL COUNSELING

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.
Limit: three visits per Claimant Lifetime (diabetic counseling is not subject to this limit). Nutritional counseling visits that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services.	

ORTHOTIC DEVICES

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

The Plan covers benefits for the purchase of braces, splints, orthopedic appliances and orthotic supplies or apparatuses used to support, align or correct deformities or to improve the function of moving parts of the body. Benefits under the Plan may be reduced for a less costly alternative item. The Plan does not cover off-the-shelf shoe inserts and orthopedic shoes.

PALLIATIVE CARE

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.
Limit: 30 visits per Claimant per Calendar Year	

The Plan covers palliative care when a Provider has assessed that a Claimant is in need of palliative services. For the purpose of this benefit, "palliative care" means specialized services received from a Provider in a home setting for counseling and home health aide services for activities of daily living. Palliative care visits that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services.

PRESCRIPTION MEDICATIONS

For Prescription Medications from a Pharmacy

After Deductible, the Plan pays 80% and You pay 20% of the Covered Prescription Medication Expense for each Generic Medication or Brand-Name Medication. Your 20% payment will be applied toward the Out-of-Pocket Maximum.

For Prescription Medications from a Mail-Order Supplier

After Deductible, the Plan pay 80% and You pay 20% of the Covered Prescription Medication Expense for each Generic Medication or Brand-Name Medication. Your 20% payment will be applied toward the Out-of-Pocket Maximum.

For Prescription Medications from a Specialty Pharmacy

The same Cost Sharing listed above for Prescription Medications from a Pharmacy apply to Specialty Medications obtained from a Specialty Pharmacy.

Covered Prescription Medications

Benefits under this Prescription Medications provision are available for the following:

- diabetic supplies (including test strips, glucagon emergency kits, insulin and insulin syringes, but not insulin pumps and their supplies), when obtained with a Prescription Order (insulin pumps and their supplies are covered under the Durable Medical Equipment benefit);
- Prescription Medications;
- certain preventive medications (including, but not limited to, aspirin, fluoride, iron and Generic Medications for tobacco use cessation) according to, and as recommended by, the USPSTF, when obtained with a Prescription Order;
- FDA-approved women's prescription and over-the-counter (if presented with a Prescription Order) contraception methods as recommended by the HRSA. These include female condoms, diaphragm with spermicide, sponge with spermicide, cervical cap with spermicide, spermicide, oral contraceptives (combined pill, mini pill, and extended/continuous use pill), contraceptive patch, vaginal ring, contraceptive shot/injection and emergency contraceptives (both levonorgestrel- and ulipristal acetate-containing products);
- immunizations for adults and children according to, and as recommended by, the CDC;
- Specialty Medications; and
- Self-Administrable Prescription Medications (including, but not limited to, Self-Administrable Compound and Injectable Medications).

You are not responsible for any applicable Deductible and/or Cost Sharing when You fill prescriptions at a Participating Pharmacy for specific strengths or quantities of medications that are specifically designated as preventive medications, women's contraceptives, or for immunizations, as specified above. For a list of such medications, please visit the Claims Administrator's Web site at **www.Regence.com** or contact the Claims Administrator's Customer Service at 1 (866) 240-9580. Also, if Your Provider believes that the Plan's covered preventive medications, including women's contraceptives, are medically inappropriate for You, You may request a coverage exception for a different preventive medication by contacting the Claims Administrator's Customer Service. NOTE: The applicable Deductible and/or Cost Sharing as listed in this Prescription Medications benefit will apply when You fill preventive medications and immunizations that meet the above criteria, at a Nonparticipating Pharmacy.

Pharmacy Network Information

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

The Plan identification card enables You to participate in this Prescription Medication program, so You must use it to identify Yourself at any Pharmacy. If You do not identify Yourself as a Claimant through Regence BlueShield of Idaho, Inc., a Participating Pharmacy or Mail-Order Supplier may charge You more than the Covered Prescription Medication Expense. You can find Participating Pharmacies and a Pharmacy locator on the Claims Administrator's Web site at **www.Regence.com** or by contacting Customer Service at 1 (866) 240-9580.

Preauthorization

Preauthorization may be required to establish that a Prescription Medication is Medically Necessary before it is dispensed. The Claims Administrator publishes a list of those medications that currently require preauthorization. You can see the list on their Web site at **www.Regence.com**, or contact Customer Service at 1 (866) 240-9580. In addition, participating Providers, including Pharmacies, are notified which Prescription Medications require preauthorization. The prescribing Provider must provide

the medical information necessary to determine Medical Necessity of Prescription Medications that require preauthorization.

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

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

- **Maximum 30-Day or Greater Supply Limit**
  - **Injectable Medications and 30-Day Supply.** The largest allowable quantity for Self-Administrable Injectable Medications purchased from a Pharmacy or Mail-Order Supplier, is a 30- day supply. The Cost Sharing for Self-Administrable Injectable Medications purchased from a Mail-Order Supplier will be the same as if the medication was purchased from and the claim was submitted electronically by a Pharmacy.
  - **Specialty Medications and 30-Day Supply.** The largest allowable quantity for a Specialty Medication purchased from a Specialty Pharmacy, is a 30-day supply.
  - **Mail-Order and 90-Day Supply.** The largest allowable quantity of a Prescription Medication purchased from a Mail-Order Supplier is a 90-day supply. A Provider may choose to prescribe or You may choose to purchase, some medications in smaller quantities. Self-Administrable Injectable Medications are limited to a 30-day supply as indicated above. You may also obtain covered Prescription Medications from a non-contracted mail-order Pharmacy, if the noncontracted mail-order Pharmacy is registered and agrees to dispense covered Prescription Medications under the same terms and conditions as those provided by a Mail-Order Supplier. In this case, covered Prescription Medications dispensed by the non-contracted mail-order Pharmacy will be covered in the same manner as covered Prescription Medications dispensed by a Mail-Order Supplier.
  - **Pharmacy and 90-Day Supply.** The largest allowable quantity of a Prescription Medication purchased from a Pharmacy is a 90-day supply. A Provider may choose to prescribe, or You may choose to purchase, some medications in smaller quantities.
  - **Pharmacy and 90-Day Multiple-Month Supply.** The largest allowable quantity of a covered Prescription Medication that is packaged exclusively in a multiple-month supply and is purchased from a Pharmacy is the smallest multiple-month supply packaged by the manufacturer for dispensing by Pharmacies. The availability of that supply at a given Pharmacy or time is not a factor in identifying the smallest multiple-month supply. The maximum supply covered for these products is a 90-day supply (even if the packaging includes a larger supply).

- **Maximum 30 Quantity Limit**
  For certain Prescription Medications, the Claims Administrator establishes maximum quantities other than those described previously. This means that, for those medications, there is a limit on the amount of medication that will be covered during a period of time. The Claims Administrator uses information from the FDA and from scientific publications to establish these maximum quantities. When You take a Prescription Order to a Participating Pharmacy or request a Prescription Medication refill and use The Plan identification card, the Pharmacy will let You know if a quantity limitation applies to the medication. You may also find out if a limit applies by contacting Customer

Service at 1 (866) 240-9580. The Plan does not cover any amount over the established maximum quantity, except if it is determined the amount is Medically Necessary. The prescribing Provider must provide medical information in order to establish whether the amount in excess of the established maximum quantity is Medically Necessary.

- **Refills**
  The Plan will cover refills from a Pharmacy when You have taken 75 percent of the previous prescription. Refills obtained from a Mail-Order Supplier are allowed after You have taken all but 20 days of the previous Prescription Order. If You choose to refill Your Prescription Medications sooner, You will be responsible for the full costs of these Prescription Medications and these costs will not count toward Your Deductible (if applicable) or any Out-of-Pocket Maximum. If You feel You need a refill sooner than allowed, a refill exception will be considered at the Claims Administrator's discretion on a case-by-case basis. You may request an exception by calling Customer Service at 1 (866) 240- 9580.

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

Exclusions

In addition to the exclusions in the General Exclusions Section, the following exclusions apply to this Prescription Medications benefit, unless specifically defined by the Claims Administrator:

Biological Sera, Blood or Blood Plasma

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

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

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

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

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

Nonprescription Medications: Except for medications included on the Claims Administrator's Formulary, approved by the FDA or a Prescription Order by a Physician or Practitioner, the Plan does not cover medications that by law do not require a Prescription Order, including vitamins, minerals, food supplements, homeopathic medicines and nutritional supplements.

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

Prescription Medications for Treatment of Infertility

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

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

Prescription Medications without Examination: Except as provided under the Telehealth and Telemedicine benefits in this Medical Benefits Section, the Plan does not cover prescriptions made by a Provider without recent and relevant in-person examination of the patient, whether the Prescription Order is provided by mail, telephone, internet or some other means. For purposes of this exclusion, an examination is "recent" if it occurred within 12 months of the date of the Prescription Order and is "relevant" if it involved the diagnosis, treatment or evaluation of the same or a related condition for which the Prescription Medication is being prescribed. Additionally, this exclusion does not apply to a Provider or Pharmacist who may prescribe: 1) an opioid antagonist to a Claimant who is at risk of experiencing an opiate-related overdose; or 2) an epinephrine auto-injector to a Claimant who is at risk of experiencing anaphylaxis.

Professional Charges for Administration of Any Medication

Definitions

In addition to the definitions in the Definitions Section, the following definitions apply to this Prescription Medications benefit:

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

Compound Medication means two or more medications that are mixed together by the Pharmacist. To be covered, Compound Medications must contain a Prescription Medication that has been approved by the FDA.

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

Formulary means the Claims Administrator's list of selected Prescription Medications. The Claims Administrator established and routinely reviews and updates the Formulary. It is available on the Claims Administrator's Web site at **www.Regence.com** or by calling Customer Service at 1 (866) 240-9580. Medications are reviewed and selected for inclusion in the Formulary by an outside committee of providers, including Physicians and Pharmacists.

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

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

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

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

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

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

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

Specialty Medications means medications used by patients with complex disease states, such as but not limited to multiple sclerosis, rheumatoid arthritis, cancer and hepatitis C. For a list of some of these medications, please visit the Claims Administrator's Web site at **www.Regence.com** or contact Customer Service at 1 (866) 240-9580.

Specialty Pharmacy means a Pharmacy that specializes in the distribution and medication management services of high cost injectiables and Specialty Medications. To find a Specialty Pharmacy, please visit the Claims Administrator's Web site at **www.Regence.com** or contact Customer Service at 1 (866) 240-9580.

PROSTHETIC DEVICES

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

The Plan covers prosthetic devices for functional reasons to replace a missing body part, including artificial limbs, external or internal breast prostheses following a mastectomy and maxillofacial prostheses. Prosthetic devices or appliances that are surgically inserted into the body are otherwise covered under the appropriate facility benefit (Hospital Care or Ambulatory Surgical Center) in this Medical Benefits Section. Repair or replacement of a prosthetic device due to normal use or growth of a child will be covered under the Plan.

REHABILITATION SERVICES

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.
Inpatient limit: 22 days per Claimant per Calendar Year **Outpatient limit:** 30 visits per Claimant per Calendar Year	

The Plan covers inpatient and outpatient rehabilitation services (physical, occupational and speech therapy services only) and accommodations as appropriate and necessary to restore or improve lost function caused by Injury or Illness. Rehabilitation days or visits that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services. You will not be eligible for both the Neurodevelopmental Therapy benefit and this benefit for the same services for the same condition.

SKILLED NURSING FACILITY (SNF) CARE

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.
Limit: 60 inpatient days per Claimant per Calendar Year	

The Plan covers the inpatient services and supplies of a Skilled Nursing Facility for Illness, Injury or physical disability. Room and board is limited to the Skilled Nursing Facility's average semiprivate room rate, except where a private room is determined to be necessary. Skilled Nursing Facility days that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services. Ancillary services and supplies, such as physical therapy, Prescription Medications, and radiology and laboratory services, billed as part of a Skilled Nursing Facility admission also apply toward any Maximum Benefit limit on Skilled Nursing Facility care.

SPINAL MANIPULATIONS

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.
Limit: 18 spinal manipulations per Claimant per Calendar Year	

The Plan covers spinal manipulations performed by any Provider. Spinal manipulations that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services. Manipulations of extremities are covered under the Neurodevelopmental Therapy and Rehabilitation Services benefits in this Medical Benefits Section.

TELEHEALTH

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 25% of the Allowed Amount and You pay balance of billed charges. Your 75% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

The Plan covers telehealth (audio and video communication) office visits for primary care services and equivalent behavioral health services between the patient and the Plan Sponsor's chosen telehealth Provider. NOTE: Telehealth services are prohibited in some states and therefore You will not be covered for these services if You attempt to access them while in one of those states. Please contact the Claims Administrator for further information and guidance. Coverage is not provided under this benefit for all non-real-time delivery methods, including, but not limited to, store and forward solutions, e-mail or secure message exchange.

TELEMEDICINE

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

The Plan covers telemedicine (audio and video communication) services between a distant-site Physician, the patient and a consulting Practitioner when the originating (distant) site is a rural health professional shortage area as defined by the Centers for Medicare and Medicaid Services.

TEMPOROMANDIBULAR JOINT (TMJ) DISORDERS

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

The Plan covers inpatient and outpatient services for treatment of temporomandibular joint (TMJ) disorders which have one or more of the following characteristics:

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

"Covered services" for the purpose of this TMJ benefit, mean those services that are:

- reasonable and appropriate for the treatment of a disorder of the TMJ, under all the factual circumstances of the case;
- effective for the control or elimination of one or more of the following, caused by a disorder of the TMJ: pain, infection, disease, difficulty in speaking or difficulty in chewing or swallowing food;
- recognized as effective, according to the professional standards of good medical practice; and
- not Investigational or primarily for Cosmetic purposes.

TRANSPLANTS

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

The Plan covers transplants, including transplant-related services and supplies for covered transplants. A transplant recipient who is covered under this Plan and fulfills Medically Necessary criteria will be eligible for the following transplants: heart, lung, kidney, pancreas, liver, cornea, multivisceral, small bowel, islet cell and hematopoietic stem cell support (donor stem cells can be collected from either the bone marrow or the peripheral blood). Hematopoietic stem cell support may involve the following donors, for example, either autologous (self-donor), allogeneic (related or unrelated donor), syngeneic (identical twin donor) or umbilical cord blood (only covered for certain conditions). This list of transplants is subject to change. Claimants can contact the Claims Administrator for a current list of covered transplants.

Donor Organ Benefits
The Plan covers donor organ procurement costs if the recipient is covered for the transplant under this Plan. Procurement benefits are limited to selection, removal of the organ, storage, transportation of the surgical harvesting team and the organ and other such procurement costs that are determined to be paid under the Plan.

Care Management Program

Because of Regence BlueShield of Idaho, Inc.'s involvement as the Claims Administrator, You have access to the following Group-sponsored care management program. The Trust has chosen to provide this benefit to You. To the extent any part of these programs (for example, medications for smoking cessation) is also a benefit under the Medical Benefits or other benefit of the Plan, the Medical Benefits or other benefit applies first and until that benefit is exhausted.

CASE MANAGEMENT
Receive one-on-one help and support in the event You have a serious or sudden Illness or Injury. An experienced, compassionate case manager will serve as Your personal advocate during a time when You need it most. Your case manager is a licensed health care professional who will help You understand Your treatment options, show You how to get the most out of Your available Plan benefits and work with Your Physician to support Your treatment plan.

To learn more or to make a referral to case management, please call 1 (866) 543-5765.

General Exclusions

The following are the general exclusions from coverage under the Plan. Other exclusions may apply and, if so, will be described elsewhere in this Summary Plan Description.

SPECIFIC EXCLUSIONS
The Plan will not provide benefits for any of the following conditions, treatments, services, supplies or accommodations, **including any direct complications or consequences that arise from them**.
However, these exclusions will not apply with regard to an otherwise Covered Service for: 1) an Injury if the Injury results from an act of domestic violence or a medical condition (including physical and mental) and regardless of whether such condition was diagnosed before the Injury, as required by federal law; or 2) a preventive service as specified under the Preventive Care and Immunizations benefit and the Prescription Medications benefit in the Medical Benefits Section.

Activity Therapy
Creative arts, play, dance, aroma, music, equine, recreational or similar therapy; sensory movement groups; and wilderness or adventure programs.

Acupuncture

Applied Behavior Analysis (ABA) Therapy
Benefits are only payable for applied behavior analysis (ABA) services from providers that have a current Board Certified Behavioral Analysis certification issued by the Behavioral Analyst Certification Board.

Assisted Reproductive Technologies

Assisted reproductive technologies (including, but not limited to, in vitro fertilization, artificial insemination, embryo transfer or other artificial means of conception), or associated surgery, drugs, testing or supplies, regardless of underlying condition or circumstance.

Certain Therapy, Counseling and Training

Educational, vocational, social, image, milieu or marathon group therapy, premarital or marital counseling,
Employee Assistance Program (EAP) services, except as provided under the EAP Section, if applicable; job skills or sensitivity training.

Conditions Caused By Active Participation In a War or Insurrection

The treatment of any condition caused by or arising out of a Claimant's active participation in a war or insurrection.

Conditions Incurred In or Aggravated During Performances In the Uniformed Services

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

Cosmetic/Reconstructive Services and Supplies

- Cosmetic and/or reconstructive services and supplies, except in the treatment of the following:

- to treat a Congenital Anomaly for Claimants up to age 26;
- to restore a physical bodily function lost as a result of Injury or Illness; or
- related to breast reconstruction following a Medically Necessary mastectomy, to the extent required by law. For more information on breast reconstruction, see the Women's Health and Cancer Rights notice in this Summary Plan Description.

Cosmetic means services or supplies that are applied to normal structures of the body primarily to improve or change appearance.

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

Counseling in the Absence of Illness

Except as required by law, the Plan does not cover counseling in the absence of Illness.

Custodial Care

Except as provided under the Palliative Care benefit in this Summary Plan Description, the Plan does not cover non-skilled care and helping with activities of daily living.

Dental Services

The Plan does not cover Dental Services provided to prevent, diagnose or treat diseases or conditions of the teeth and adjacent supporting soft tissues, including treatment that restores the function of teeth.

Elective Abortion
Except when performed to preserve the life of the enrolled female Claimant, the Plan does not cover termination of pregnancy (elective abortion).

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

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

Fees, Taxes, Interest
Charges for shipping and handling, postage, interest or finance charges that a Provider might bill. The Plan also does not cover excise, sales or other taxes; surcharges; tariffs; duties; assessments; or other similar charges whether made by federal, state or local government or by another entity, unless required by law.

Government Programs
Benefits that are covered, or would be covered in the absence of this Plan, by any federal, state or government program, except for facilities that contract with the Claims Administrator and except as required by law, such as for cases of medical emergency or for coverage provided by Medicaid. Expenses from government facilities outside the service area are not covered under the Plan (except for facilities contracting with the local Blue Cross and/or Blue Shield plan or as required by law for emergency services).

Growth Hormone Therapy
Except as provided under the Prescription Medications benefit in this Summary Plan Description, the Plan does not cover growth hormone therapy.

Hearing Care
The Plan does not cover hearing care, routine hearing examinations, programs or treatment for hearing loss, including, but not limited to, hearing aids (externally worn or surgically implanted) and the surgery and services necessary to implant them. This exclusion does not apply to cochlear implants.

Hypnotherapy and Hypnosis Services
Hypnotherapy and hypnosis services and associated expenses, including, but not limited to, use of such services for the treatment of painful physical conditions, Mental Health Conditions, Substance Use Disorders or for anesthesia purposes.

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

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

Infertility
Except to the extent Covered Services are required to diagnose such condition, the Plan does not cover treatment of infertility including, but not limited to, surgery, fertility drugs and medications.

Investigational Services
Except as provided under the Approved Clinical Trials benefit in this Summary Plan Description, the Plan does not cover Investigational treatments or procedures (Health Interventions) services, supplies and accommodations provided in connection with Investigational treatments or procedures (Health Interventions). Also excluded are any services or supplies provided under an Investigational protocol. Refer to the expanded definition in the Definitions Section in this Summary Plan Description.

Motor Vehicle Coverage and Other Available Insurance
Expenses for services and supplies that are payable under any automobile medical, personal injury protection (PIP), or automobile no-fault coverage (unless the automobile contract contains a coordination of benefits provision, in which case, the Coordination of Benefits provision in this Summary Plan Description shall apply); underinsured or uninsured motorist coverage, homeowner's coverage, commercial premises coverage, excess coverage or similar contract or insurance. This applies when the contract or insurance is either issued to, or makes benefits available to a Claimant, whether or not the Claimant makes a claim under such coverage. Further, the Claimant is responsible for any cost-sharing required by the other insurance coverage, unless applicable state law requires otherwise. Once benefits under such contract or insurance are exhausted or considered to no longer be Injury-related under the no-fault provisions of the contract, benefits will be provided according to this Summary Plan Description.

Non-Direct Patient Care
Services that are not direct patient care, including:

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

Obesity or Weight Reduction/Control
Except as may be specifically provided in this Summary Plan Description or as required by law, the Plan does not cover medical treatment, medications, surgical treatment (including treatment of complications, revisions and reversals), programs or supplies that are intended to result in or relate to weight reduction, regardless of diagnosis or psychological conditions.

Orthognathic Surgery
Except for orthognathic surgery due to an Injury, temporomandibular joint disorder, sleep apnea or Congenital Anomaly, the Plan does not cover services and supplies for orthognathic surgery. "Orthognathic surgery" means surgery to manipulate facial bones, including the jaw, in patients with facial bone abnormalities resulting from abnormal development to restore the proper anatomic and functional relationship of the facial bones.

Over-the-Counter Contraceptives

Except as provided under the Prescription Medications benefit in this Summary Plan Description or as required by law, the Plan does not cover over-the-counter contraceptive supplies.

Personal Comfort Items
Items that are primarily for comfort, convenience, cosmetics, environmental control or education. For example, telephones, televisions, air conditioners, air filters, humidifiers, whirlpools, heat lamps and light boxes are not covered.

Physical Exercise Programs and Equipment
Physical exercise programs or equipment, including hot tubs or membership fees at spas, health clubs or other such facilities. This exclusion applies even if the program, equipment or membership is recommended by the Claimant's Provider.

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

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

Riot, Rebellion and Illegal Acts
Services and supplies for treatment of an Illness, Injury or condition caused by a Claimant's **voluntary participation in** a riot, armed invasion or aggression, insurrection or rebellion or sustained by a Claimant arising directly from an act deemed illegal by an officer or a court of law.

Routine Foot Care

Self-Help, Self-Care, Training or Instructional Programs
Except as may be specifically provided in this Summary Plan Description, the Plan does not cover self-help, non-medical self-care, training programs, including: :

- childbirth-related classes including infant care; and
- instruction programs including those that teach a person how to use Durable Medical Equipment or how to care for a family member.

This exclusion does not apply to services for training or educating a Claimant when provided without separate charge in connection with Covered Services or when specifically indicated as a Covered Service in the Medical Benefits Section (for example, nutritional counseling, diabetic education and teaching doses for Self-Administrable Injectable Medications).

Services and Supplies Provided by a Member of Your Family
Services and supplies provided to You by a member of Your immediate family. For purposes of this provision, "immediate family" means:

- You and Your parents, parents' spouses or domestic partners, spouse or domestic partner, children, stepchildren, siblings and half-siblings;
- Your spouse's or domestic partner's parents, parents' spouses or domestic partners, siblings and halfsiblings;
- Your child's or stepchild's spouse or domestic partner; and

- any other of Your relatives by blood or marriage who shares a residence with You.

Services and Supplies That Are Not Medically Necessary
Except for preventive care benefits provided in this Summary Plan Description, the Plan does not cover services and supplies that are not Medically Necessary for the treatment of an Illness or Injury.

Sexual Dysfunction
Except for covered Mental Health Conditions, the Plan does not cover treatment, services and supplies (including medications) for or in connection with sexual dysfunction regardless of cause.

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

Travel and Transportation Expenses
Travel and transportation expenses other than covered ambulance services provided in this Summary Plan Description.

Travel Immunizations
Immunizations for purposes of travel, occupation or residency in a foreign country.

Varicose Vein Treatment
Except when there is associated venous ulceration or persistent or recurrent bleeding from ruptured veins, the Plan does not cover treatment of varicose veins.

Vision Care
The Plan does not cover routine eye exam and vision hardware.

Visual therapy, training and eye exercises, vision orthoptics, surgical procedures to correct refractive errors/astigmatism, reversals or revisions of surgical procedures which alter the refractive character of the eye.

Work-Related Conditions
Expenses for services and supplies incurred as a result of any work-related Injury or Illness, including any claims that are resolved related to a disputed claim settlement. The Claims Administrator may require the Claimant to file a claim for workers' compensation benefits before providing any benefits under this coverage. The Plan does not cover services and supplies received for work-related Injuries or Illnesses even if the service or supply is not a covered workers' compensation benefit. The only exception is if a Claimant is exempt from state or federal workers' compensation law.

Claims Administration

This section explains a variety of matters related to administering claims, including situations that may arise when Your health care expenses are the responsibility of a source other than the Plan.

PREAUTHORIZATION

Contracted Providers may be required to obtain preauthorization from the Claims Administrator in advance for certain services provided to You. You will not be penalized if the contracted Provider does not obtain those approvals from the Claims Administrator in advance and the service is determined to be not covered under this Summary Plan Description. Non-contracted Providers are not required to obtain preauthorization from the Claims Administrator in advance for services so You may be liable for costs if You elect to seek services from non-contracted Providers and those services are considered not Medically Necessary and not covered under this Summary Plan Description. You may request that a non-contracted Provider preauthorize services on Your behalf to determine Medical Necessity prior to the services being rendered.

PLAN IDENTIFICATION CARD

When Participants, enroll in the Plan, they will receive Plan identification cards. The identification card will include important information such as the Participant's identification number, group number and name.

It is important to keep The Plan identification card with You at all times. Be sure to present it to Your Provider before receiving care. If You lose Your card, or if it gets destroyed, You can get a new one by simply calling the Claims Administrator's Customer Service department at 1 (866) 240-9580. You can also view or print an image of The Plan identification card by visiting the Claims Administrator's Web site at **www.Regence.com** on Your PC or mobile device. If the Agreement terminates, The Plan identification card will no longer be valid.

SUBMISSION OF CLAIMS AND REIMBURSEMENT

A participant must submit a claim to Regence BlueShield of Idaho, Inc. in order to receive benefits for covered services. Participation in the Plan is confirmed by an identification card sent to them by Regence BlueShield of Idaho, Inc.. The participants presents their Regence BlueShield of Idaho, Inc. identification card to the health care provider (hospital, doctor, or other facility or specialist) and the provider will file the claims for the participant. If the participant has any question about filing a claim, he or she should contact Regence BlueShield of Idaho, Inc. by telephone at 1 (866) 240-9580 for assistance.

The Trust has authorized the Claims Administrator (Regence BlueShield of Idaho, Inc.) to decide whether to pay You, the Provider or You and the Provider jointly.

Benefit payments may be made for a child covered by a legal qualified medical child support order (QMCSO) directly to the custodial parent or legal guardian of such child.

Claims for the purchase of Durable Medical Equipment will be submitted to the Blue plan in the locale in which the equipment was received. Durable Medical Equipment is received where it is purchased at retail or, if shipped, where the Durable Medical Equipment is shipped to. Please refer to Your Blue plan network where supplies were received for coverage of shipped Durable Medical Equipment.

Claims for independent clinical laboratory services will be submitted to the Blue plan in the locale in which the specimen was drawn or otherwise acquired, regardless of where the examination of the specimen occurred. Please refer to Your Blue plan network where the specimen was drawn for coverage of independent clinical laboratory services.

You will be responsible for the total billed charges for benefits in excess of Maximum Benefits, if any, and for charges for any other service or supply not covered under this Plan, regardless of the Provider rendering such service or supply.

Calendar Year and Plan Year
The Deductible and Out-of-Pocket Maximum provisions are calculated on a Calendar Year basis. The Agreement is renewed, with or without changes, each Plan Year. A Plan Year is the 12-month period following either the Agreement's original Effective Date or subsequent renewal date. A Plan Year may or may not be the same as a Calendar Year. When the Agreement is renewed on other than January 1 of any year, any Deductible or Out-of-Pocket Maximum amounts You satisfied before the date the Agreement renews will be carried over into the next Plan Year. If the Deductible and/or Out-of-Pocket Maximum amount increases during the Calendar Year, You will need to meet the new requirement minus any amount You already satisfied under the previous Agreement during that same Calendar Year.

Timely Filing of Claims
Written proof of loss must be received within one year after the date of service for which a claim is made. If it can be shown that it was not reasonably possible to furnish such proof and that such proof was furnished as soon as reasonably possible, failure to furnish proof within the time required will not invalidate or reduce any claim. A claim that is not filed in a timely manner will be denied unless You can reasonably demonstrate that the claim could not have been filed in a timely manner. You may, however, Appeal the denial in accordance with the Appeal process to demonstrate that the claim could not have been filed in a timely manner.

Freedom of Choice of Provider
Nothing contained in this Summary Plan Description is designed to restrict You in selecting the Provider of Your choice for care or treatment of an Illness or Injury.

In-Network Provider Claims
You must present The Plan identification card when obtaining Covered Services from an In-Network Provider. You must also furnish any additional information requested. The Provider will furnish the Claims Administrator with the forms and information needed to process Your claim.

In-Network Provider Reimbursement
An In-Network Provider will be paid directly for Covered Services. These Providers have agreed to accept the Allowed Amount as full compensation for Covered Services. Your share of the Allowed Amount is any amount You must pay due to Deductible and/or Cost Sharing. These Providers may require You to pay Your share at the time You receive care or treatment.

Out-of-Network Provider Claims
In order for the Claims Administrator to pay for Covered Services, You or the Out-of-Network Provider must first send the claim to the Claims Administrator. Be sure the claim is complete and includes the following information:

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

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

Out-of-Network Provider Reimbursement
In most cases You will be paid directly for Covered Services provided by an Out-of-Network Provider. Out-of-Network Providers have not agreed to accept the Allowed Amount as full compensation for Covered Services. So, You are responsible for paying any difference between the amount billed by the Out-of-Network Provider and the Allowed Amount in addition to any amount You must pay due to Deductible and/or Cost Sharing. For Out-of-Network Providers, the Allowed Amount may be based upon the billed charges for some services, as determined by the Claims Administrator or as otherwise required by law.

Reimbursement Examples by Provider
Here is an example of how Your selection of In-Network or Out-of-Network Providers affects payment to Providers and Your cost sharing amount. For purposes of this example, let's assume the Plan pays 80 percent of the Allowed Amount for In-Network Providers and 60 percent of the Allowed Amount for Out-of- Network Providers. The benefit table from the Medical Benefits Section (or other benefits section) would appear as follows:

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

Now, let's assume that the Provider's charge for a service is $5,000 and the Allowed Amount for that charge is $4,000 for an In-Network Provider. Finally, let's assume that You have met the Deductible and that You have not met the Out-of-Pocket Maximum. Here's how that Covered Service would be paid:

- In-Network Provider: the Plan would pay 80 percent of the Allowed Amount and You would pay 20 percent of the Allowed Amount, as follows:

  - Amount In-Network Provider must "write-off" (that is, cannot charge You for): $1,000
  - Amount the Plan pays (80% of the $4,000 Allowed Amount): $3,200
  - **Amount You pay** (20% of the $4,000 Allowed Amount): **$800**
  - Total: $5,000

- Out-of-Network Provider: the Plan would pay 60 percent of the Allowed Amount. Because the Out-of-Network Provider does not accept the Allowed Amount, You would pay 40 percent of the Allowed Amount, plus the $1,000 difference between the Out-of-Network Provider's billed charges and the Allowed Amount, as follows:

  - Amount the Plan pays (60% of the $4,000 Allowed Amount): $2,400
  - **Amount You pay** (40% of the $4,000 Allowed Amount and the $1,000 difference between the billed charges and the Allowed Amount): **$2,600**
  - Total: $5,000

The actual benefits in the Plan may vary, so please read the benefits sections thoroughly to determine how Your benefits are paid. For example, as explained in the Definitions Section, the Allowed Amount may vary for a Covered Service depending upon Your selected Provider.

Ambulance Claims
When You or Your Provider forwards a claim for ambulance services to the Claims Administrator, it must show where the patient was picked up and where he or she was taken. It should also show the date of service, the patient's name and the patient's group and identification numbers.

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

Prescription Medication Claims Not Submitted Electronically
When a claim is not submitted electronically, You must pay for the Prescription Medication in full at the time of purchase. For reimbursement, simply complete a Prescription Medication claim form and mail the form and receipt to the Claims Administrator. You will be reimbursed based on the Covered Prescription Medication Expense, less the applicable Deductible and/or Cost Sharing that would have been required had the medication been purchased from and submitted electronically by a Participating Pharmacy. Payment will be sent directly to You.

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

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

To buy Prescription Medication through the mail, simply send all of the following items to a Mail-Order Supplier at the address shown on the prescription mail-order form available on the Claims Administrator's Web site at **www.Regence.com** or from the Plan Sponsor (which also includes refill instructions):
- a completed prescription mail-order form;
- any Deductible and/or Cost Sharing; and
- the original Prescription Order.

Claims Determinations
Within 30 days of the Claims Administrator's receipt of a claim, You will be notified of the action taken on it. However, this 30-day period may be extended by an additional 15 days in the following situations:
- When action cannot be taken on the claim due to circumstances beyond the Claims Administrator's control, they will notify You within the initial 30-day period that an extension is necessary. This

notification includes an explanation of why the extension is necessary and when the Claims Administrator expects to act on the claim.
- When action cannot be taken on the claim due to lack of information, the Claims Administrator will notify You within the initial 30-day period that the extension is necessary. This notification includes a specific description of the additional information needed and an explanation of why it is needed.

If the Claims Administrator seeks additional information from You, You will be allowed at least 45 days to provide the additional information. If the Claims Administrator does not receive the requested information to process the claim within the time allowed, the claim will be denied.

OUT-OF-AREA SERVICES
The Claims Administrator has a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association. Whenever You access health care services outside the geographic area the Claims Administrator serves, the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When care is received outside of the Claims Administrator's service area, it will be received from one of two kinds of Providers. Most Providers ("In-Network Providers") contract with the local Blue Cross and/or Blue Shield Licensee in that geographic area ("Host Blue"). Some Providers ("Out-of-Network Providers") don’t contract with the Host Blue. This section explains below how the Plan pays both kinds of Providers.

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

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

- The billed covered charges for Your Covered Services; or
- The negotiated price that the Host Blue makes available to the Claims Administrator.

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

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

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

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

Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees
Federal law or state law may require a surcharge, tax or other fee that applies to insured accounts. If applicable, the Claims Administrator will include any such surcharge, tax or other fee as part of the claim charge passed on to You.

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

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

If You need medical assistance services (including locating a doctor or Hospital) outside the BlueCard service area, You should call the BlueCard Worldwide Service Center at 1 (800) 810-BLUE or call collect

at 1 (804) 673-1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a Physician appointment or hospitalization, if necessary.

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

- **Outpatient Services**

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

- **Submitting a BlueCard Worldwide Claim**

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

NONASSIGNMENT AND NONASSIGNMENT OF VOTING RIGHTS

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

A Plan holder entitled to vote on any matter of corporation business may not assign or in any way delegate such voting right to any other person or entity, other than by a validly executed written proxy filed with the Claims Administrator in compliance with the Claims Administrator's bylaws.

CLAIMS RECOVERY

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

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

This Claims Recovery provision in no way reduces the Plan's right to reimbursement or subrogation. Refer to the other-party liability provision in the Claims Administration Section for additional information.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION AND MEDICAL RECORDS

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

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

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

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

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

The Claims Administrator is required by law to protect Your personal health information, and must obtain prior written authorization from You to release information not related to routine health coverage. A Notice of Privacy Practices is available by calling the Claims Administrator's Customer Service department or visiting their Web site **www.Regence.com**.

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

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

LIMITATIONS ON LIABILITY
In all cases, You have the exclusive right to choose a health care Provider. Neither the Plan nor the Claims Administrator is responsible for the quality of health care You receive, since all those who provide care do so as independent contractors. Since neither the Plan nor the Claims Administrator provides any health care services, neither can be held liable for any claim or damages connected with Injuries You suffer while receiving health services or supplies provided by professionals who are neither employees nor agents of the Plan or the Claims Administrator.

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

SUBROGATION AND RIGHT OF RECOVERY
The provisions of this section apply to all current or former Claimants who incur claims and are or have been covered by the Plan. The Plan's right to recover (whether by subrogation or reimbursement) shall apply to the personal representative of Your estate, Your decedents, minors, and incompetent or disabled persons. No adult Claimant hereunder, may assign any rights that it may have to recover expenses from any tortfeasor or other person or entity to any minor child or children of said adult Claimant without the prior express written consent of the Plan.

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

This Plan is always secondary to automobile no-fault coverage, personal injury protection coverage, or medical payments coverage, excess coverage or similar contract or insurance.
No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until this Plan's subrogation and reimbursement interest are fully satisfied.

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

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

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

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

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

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

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

Cooperation
You agree to cooperate fully with the Plan's efforts to recover benefits paid. It is Your duty to notify the Plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of Your intention to pursue or investigate a claim to recover damages or obtain compensation due to Your Injury, Illness or condition. You and Your agents agree to provide the Plan or its representatives notice of any recovery You or Your agents obtain prior to receipt of such recovery funds or within five days if no notice was given prior to receipt of recovery funds. Further, You and Your agents agree to provide notice prior to any disbursement of settlement or any other recovery funds obtained. You and Your agents shall provide all information requested by the Plan, the Claims Administrator or its representative including, but not limited to, completing and submitting any applications or other forms

or statements as the Plan may reasonably request and all documents related to or filed in personal injury litigation. Failure to provide this information, failure to assist the Plan in pursuit of its subrogation rights or failure to reimburse the Plan from any settlement or recovery You receive may result in the denial of any future benefit payments or claim until the Plan is reimbursed in full, termination of Your health benefits or the institution of court proceedings against You.

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

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

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

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

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

Jurisdiction
By accepting benefits from the Plan, You agree that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the Plan may elect. By accepting such benefits, You hereby submit to each such jurisdiction, waiving whatever rights may correspond by reason of Your present or future domicile. By accepting such benefits, You also agree to pay all attorneys' fees the Plan incurs in successful attempts to recover amounts the Plan is entitled to under this section.

COORDINATION OF BENEFITS

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

Coordination of Benefits Under an HSA Plan
This high deductible health Plan was designed for use in conjunction with a health savings account (HSA), but can be maintained without an HSA. Laws strictly limit the types of other coverages that an HSA participant may carry in addition to his or her high deductible health plan. The benefits of maintaining an HSA are jeopardized if impermissible types of other coverages are maintained. Benefits will be coordinated according to this Coordination of Benefits provision, regardless of whether other coverage is permissible under HSA law or not. It is Your responsibility to ensure that You do not maintain other coverage that might jeopardize any HSA tax benefit that You plan to claim.

Benefits Subject to this Provision
All of the benefits provided in this Summary Plan Description are subject to this Coordination of Benefits provision.

Definitions
In addition to the definitions in the Definitions Section, the following are definitions that apply to this Coordination of Benefits Section:

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

- An expense or portion of an expense excluded by this Plan and all relevant other Plans.
- The difference between the cost of a private Hospital room and the cost of a semiprivate Hospital room, unless Your stay in a private Hospital room is Medically Necessary or this Plan or another Plan provides coverage for private Hospital rooms. When this coverage restricts coordination of benefits to certain types of coverage or benefits, any expenses for other types of coverage or benefits. See the Benefits Subject to this Provision paragraph, above, for restrictions on the types of coverage or benefits to which coordination applies.
- Any amount by which a Primary Plan's benefits were reduced because You did not comply with that Plan's provisions regarding second surgical opinion or failed to use a preferred Provider.
- A Primary Plan's deductible, if the Primary Plan is a high deductible health plan as defined in the Internal Revenue Code and the Claims Administrator is notified both that all plans covering a person are high deductible health plans and that the person intends to contribute to a health savings account in accordance with the Internal Revenue Code.

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

Birthday, for purposes of these Coordination of Benefits provisions, means only the day and month in a Calendar Year and does not include the year in which the Claimant is born.

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

non-panel provider, except for emergency services or authorized referrals that are provided by the Primary Plan.

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

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

Plan means any of the following with which this coverage coordinates benefits:
- Group and non-group insurance contracts and subscriber contracts;
- Uninsured group or Group-Type Coverage arrangements;
- Group and non-group coverage through Closed Panel Plans;
- Group-Type Coverage;
- Medical care components of long-term care coverage, such as skilled nursing care;
- Medicare or other governmental benefits, except as provided below; and
- Medical benefits coverage in automobile "no fault" and traditional automobile "fault" type contracts.

Plan does not include:
- Hospital indemnity coverage or other fixed indemnity coverage;
- School accident-type coverage that covers students for accidents only, including athletic injuries, either on a 24-hour basis or a "to and from school basis";
- Specified disease or specified accident coverage;
- Accident only coverage;
- Long-term care insurance for non-medical services (such as personal care, adult daycare, homemaker services, assistance with activities of daily living, respite care, and Custodial Care) or that pay a fixed daily benefit without regard to actual expenses incurred or services;
- Limited benefit health coverage (as defined in IDAPA 18.01.30);
- Medicare supplement coverage;
- A state plan under Medicaid; or
- A governmental plan that, by law, provides benefits that are excess to those of private insurance or other nongovernmental coverage.

Primary Plan means the Plan that must determine its benefits for Your health care before the benefits of another Plan and without taking the existence of that other Plan into consideration. (This is also referred to as that Plan being "primary" to that other Plan.) There may be more than one Primary Plan. A Plan is a Primary Plan with regard to another Plan in any of the following circumstances:
- The Plan either has no order of benefit determination provision, or its rules differ from those permitted under this provision; or
- Both Plans use the order of benefit determination provision included herein and under that provision the Plan determines its benefits first.

Secondary Plan means a Plan that is not a Primary Plan. You may have more than one Secondary Plan.

If You are covered under more than one Secondary Plan, the order of benefit determination provision decides the order in which Your Secondary Plans' benefits are determined in relation to each other.

Year, for purposes of this Coordination of Benefits provision, means Calendar Year (January 1 through December 31).

Order of Benefit Determination

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

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

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

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

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

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

- If a court decree specifies that one of Your parents is responsible for Your health care expenses or health care coverage and that parent's Plan has actual knowledge of that term of the decree, the Plan of that parent is primary to the Plan of Your other parent. If the parent with responsibility has no health care coverage for Your health care expenses, but that parent's spouse does, that parent's spouse's Plan is the Primary Plan. If benefits have been paid or provided by a Plan before it has actual knowledge of the term in the court decree, these rules do not apply until that Plan's next Contract Year.
- If a court decree states that both parents are responsible for Your health care expenses or health care coverage, or a court decree states that the parents have joint custody without specifying that one parent has responsibility for Your health care expenses or health care coverage:
    - The Plan that covers You as the dependent of Your parent whose Birthday occurs earlier in the Year will be primary over a Plan that covers You as the dependent of Your parent whose Birthday occurs later in the Year.
    - If both parents covering You as a dependent have the same Birthday, the Plan of the parent who has been covered by his or her Plan longer shall be primary to the Plan of the parent who has been covered by his or her Plan for a shorter period.

- If there is no court decree allocating responsibility for Your health care expenses or health care coverage:
    - The Plan covering the Custodial Parent shall be primary to the Plan covering Your Custodial Parent's spouse;

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

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

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

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

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

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

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

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

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

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

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

The benefits that would have been paid under this Plan for a service if this coverage were the Primary Plan will be calculated. The Allowable Expense in this Plan for that service will be compared to the Allowable Expense for it under the other Plan(s) by which You are covered. This Plan will pay the lesser of:

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

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

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

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

Right to Receive and Release Needed Information

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

Facility of Payment

Any payment made under any other Plan(s) may include an amount that should have been paid under this coverage. If so, that amount may be paid under this Plan to the organization that made the payment.
That amount will then be treated as though it were a benefit paid under this coverage. That amount will not have to be paid under this Plan again. The term "payment made" includes providing benefits in the

form of services, in which case payment made means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

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

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

Appeal Process

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

APPEALS

Appeals can be initiated through either written or verbal request. A written request can be made by sending it to the Claims Administrator at: Attn: Appeals, Regence BlueShield of Idaho, Inc., P.O. Box 2998, Tacoma, WA 98401-2998 or facsimile 1 (877) 663-7526. Verbal requests can be made by calling the Claims Administrator at 1 (866) 240-9580.

Each level of Appeal, except voluntary external review, must be pursued within 180 days of Your receipt of the Claims Administrator's determination (or, in the case of the first level, within 180 days of Your receipt of the Claims Administrator's original adverse decision that You are Appealing). You, or Your Representative on Your behalf, will be given a reasonable opportunity to provide written materials. If You don't Appeal within this time period, You will not be able to continue to pursue the Appeal process and may jeopardize Your ability to pursue the matter in any forum.

If Your health could be jeopardized by waiting for a decision under the regular Appeal process, an expedited Appeal may be requested. Please see Expedited Appeals later in this section for more information.

First-Level Appeals

First-level Appeals are reviewed by a Claims Administrator employee or employees who were not involved in the initial decision that You are Appealing. In Appeals that involve issues requiring medical judgment, the decision is made by the Claims Administrator's staff of health care professionals. For Post-Service Appeals, a written notice of the decision will be sent within 30 days of receipt of the Appeal. For Appeals involving a Pre-Service preauthorization of a procedure, the Claims Administrator will send a written notice of the decision within 15 days of receipt of the Appeal.

Second-Level Appeals
Second-level Appeals are reviewed by a Claims Administrator employee or employees who were not involved in, or subordinate to anyone involved in, the initial or the first-level decision. For Post-Service Appeals, a written notice of the decision will be sent within 30 days of receipt of the Appeal. For Appeals involving a Pre-Service preauthorization of a procedure, the Claims Administrator will send a written notice of the decision within 15 days of receipt of the Appeal.

YOUR RIGHT TO AN INDEPENDENT EXTERNAL REVIEW

Please read this notice carefully. It describes a procedure for review of a disputed health claim by a qualified professional who has no affiliation with your health plan. If you request an independent external review of your claim, the decision made by the independent reviewer will be binding and final on the Trust. You will have the right to further review of your 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 we issue a final adverse benefit determination of your request to provide or pay for a health care service or supply, you may have the right to have our decision reviewed by health care professionals who have no association with us. You have this right only if our denial decision involved:

The medical necessity, appropriateness, health care setting, level of care, or effectiveness of your health care service or supply, or
Our determination your health care service or supply was investigational.

You must first exhaust our internal grievance and appeal process. Exhaustion of that process includes completing all levels of appeal, or unless you requested or agreed to a delay, our failure to respond to a standard appeal within 35 days in writing or to an urgent appeal within three business days of the date you filed your appeal. We may also agree to waive the exhaustion requirement for an external review request. You may file for an internal urgent appeal with us and for an expedited external review with the Idaho Department of Insurance at the same time if your request qualifies as an "urgent care request" defined below.

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

You may represent yourself in your request or you may name another person, including your treating health care provider, to act as your authorized representative for your request. If you want someone

else to represent you, you must include a signed "Appointment of an Authorized Representative" form with your request.

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

If your request qualifies for external review, our final adverse benefit determination will be reviewed by an independent review organization selected by the department. We will pay the costs of the review.

Standard External Review Request: You must file your written external review request with the department within four months after the date we issue a final notice of denial.

1. Within seven days after the department receives your request, the department will send a copy to us.
2. Within 14 days after we receive your request from the department, we will review your request for eligibility. Within five business days after we complete that review, we will notify you and the department in writing if your request is eligible or what additional information is needed. If we deny your eligibility for review, you may appeal that determination to the department.
3. If your request is eligible for review, the department will assign an independent review organization to your review within seven days of receipt of our notice. The department will also notify you in writing.
4. Within seven days of the date you receive the department's notice of assignment to an independent review organization, you may submit any additional information in writing to the independent review organization that you want the organization to consider in its review.
5. The independent review organization must provide written notice of its decision to you, to us and to the department within 42 days after receipt of an external review request.

Expedited External Review Request: You may file a written "urgent care request" with the department for an expedited external review of a pre-service or concurrent service denial. You may file for an internal urgent appeal with us and for an expedited external review with the department at the same time.

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

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

The department will send your request to us. We will determine, no later than the second full business day, if your request is eligible for review. We will notify you and the department no later than one

business day after our decision if your request is eligible. If we deny your eligibility for review, you may appeal that determination to the department.

If your request is eligible for review, the department will assign an independent review organization to your review upon receipt of our notice. The department will also notify you. The independent review organization must provide notice of its decision to you, to us and to the department within 72 hours after the date of receipt of the external review request. The independent review organization must provide written confirmation of its decision within 48 hours of notice of its decision. If the decision reverses our denial, we will notify you and the department of our intent to pay the covered benefit as soon as reasonably practicable, but not later than one business day after receiving notice of the decision.

Binding Nature of the External Review Decision: If your plan is subject to federal 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 us. You may have additional review rights provided under federal ERISA laws.

Your plan is not subject to ERISA requirements, so, the external review decision by the independent review organization will be final and binding on both the Trust and the Participant. **This means that if you elect to request external review, you will be bound by the decision of the independent review organization. You will not have any further opportunity for review of our denial after the independent review organization issues its final decision.** If you choose not to use the external review process, other options for resolving a disputed claim may include mediation, arbitration or filing an action in court.

Under Idaho law, the 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.

INFORMATION
If You have any questions about the Appeal Process outlined here, You may contact the Claims Administrator's Customer Service department at: 1 (866) 240-9580 or You can write to the Claims Administrator's Customer Service department at the following address: Regence BlueShield of Idaho, Inc., P.O. Box 2998, Tacoma, WA 98401-2998 or facsimile 1 (877) 663-7526.

DEFINITIONS SPECIFIC TO THE APPEAL PROCESS
Appeal means a written or verbal request from a Claimant or, if authorized by the Claimant, the Claimant's Representative, to change a previous decision made under the Plan concerning:

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

Independent Review Organization (IRO) is an independent Physician review organization which acts as the decision-maker for voluntary external Appeals and voluntary expedited Appeals, through an independent contractor relationship with the Claims Administrator and/or through assignment to the Claims Administrator via state regulatory requirements. The IRO is unbiased and is not controlled by the Claims Administrator.

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

Pre-Service means any claim for benefits under the Plan which must be approved in advance, in whole or in part, in order for a benefit to be paid.

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

Who Is Eligible, How to Enroll and When Coverage Begins

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

INITIALLY ELIGIBLE, WHEN COVERAGE BEGINS

You will be entitled to enroll in coverage for Yourself and Your eligible dependents within 30 days of our first becoming eligible for coverage under the eligibility requirements in effect with the Plan Sponsor and as stated in the following paragraphs. Coverage for You and Your enrolling eligible dependents will begin on the Effective Date.

Except as described under the special enrollment provision, if You and/or Your eligible dependents do not enroll for coverage under the Plan when first eligible or You do not enroll in a timely manner, You and/or Your eligible dependents must wait until the next annual enrollment period to enroll.

Employees

You become eligible to enroll in coverage on the date You have worked for the Plan Sponsor long enough to satisfy any required probationary period.

Dependents

Your Beneficiaries are eligible for coverage when You have listed them on the enrollment form or on subsequent change forms and when the Claims Administrator has enrolled them in coverage under the Plan. Dependents are limited to the following:

- The person to whom You are legally married (spouse).
- Your domestic partner, provided that all of the following conditions are met:
    - You have completed, executed and submitted an affidavit of qualifying domestic partnership form with regard to Your domestic partner;
    - Both You and Your domestic partner are age 18 or older;

  - You and Your domestic partner share a close, personal relationship and are responsible for each other's common welfare;
  - Neither You nor Your domestic partner is legally married to anyone else or has had another domestic partner within the 30 days immediately before enrollment of Your domestic partner;
  - You and Your domestic partner share the same regular and permanent residence and intend to continue doing so indefinitely;
  - You and Your domestic partner share joint financial responsibility for Your basic living expenses, including food, shelter and medical expenses; and
  - You and Your domestic partner are not more closely related by blood than would bar marriage in Your state of residence.

- Your (or Your spouse's or Your domestic partner's) child who is under age 26 and who meets any of the following criteria:
  - Your
  - (or Your spouse's or Your domestic partner's) natural child, step child, adopted child or child legally Placed with You (or Your spouse or Your domestic partner) for adoption;
  - a child for whom You (or Your spouse or Your domestic partner) have court-appointed legal guardianship; and
  - a child for whom You (or Your spouse or Your domestic partner) are required to provide coverage by a legal qualified medical child support order (QMCSO).

- Your (or Your spouse's or Your domestic partner's) otherwise eligible child who is age 26 or over and incapable of self-support because of intellectual disability or physical handicap that began before his or her 26th birthday, if You complete and submit the Claims Administrator's affidavit of dependent eligibility form, with written evidence of the child's incapacity, within 31 days of the later of the child's 26th birthday or Your Effective Date and either:
  - he or she is a Beneficiary immediately before his or her 26th birthday; or
  - his or her 26th birthday preceded Your Effective Date and he or she has been continuously covered as Your dependent on group coverage since that birthday.

The Claims Administrator's affidavit of dependent eligibility form is available by visiting their Web site at **www.Regence.com** or contacting their Customer Service department at 1 (866) 240-9580.

NEWLY ELIGIBLE DEPENDENTS

You may enroll a dependent who becomes eligible for coverage after Your Effective Date by completing and submitting an enrollment request (and, for a domestic partner, an affidavit of qualifying domestic partnership form)to the Trust. A Newborn Child's enrollment will be effective from the moment of birth if a completed enrollment form is received within 60 days following the date of birth and the appropriate contribution (if any) is received by the Trust within 31 days of the date the monthly payment invoice is received by the Trust and a notice of contribution (if any) is provided to You by the Trust. Enrollment for a Newly Adopted Child will be effective from Placement with the Participant for 60 days, but will continue from then on only if a completed enrollment form is received within 60 days following Placement with the Participant and the appropriate contribution (if any) is received by the Trust within 31 days of the date the monthly payment invoice is received by the Trust and a notice of payment (if any) is provided to You by the Trust.

NOTE: Due to the nature of this high deductible health Plan, adding dependents after January 1 of any year may change Your coverage from Single Coverage to Family Coverage, and may change the amount of Deductible and Out-of-Pocket Maximum that applies to Your coverage.

SPECIAL ENROLLMENT

There are certain situations when You may enroll Yourself and/or Your eligible dependents, even though You didn't do so when first eligible, and You do not have to wait for an annual enrollment period. Note that loss of eligibility does not include a loss because You failed to timely pay Your portion of the cost of coverage or when termination of coverage was because of fraud. It also doesn't include Your decision to terminate coverage, though it may include Your decision to take another action (for example, terminating employment) that results in a loss of eligibility.

If You are already enrolled or if You declined coverage when first eligible and subsequently have one of the following qualifying events, You (unless already enrolled), Your spouse (or Your domestic partner) and any eligible children are eligible to enroll for coverage under the Plan within 30 days from the date of the qualifying event (except that where the qualifying event is involuntary loss of coverage under Medicaid or the Children's Health Insurance Program (CHIP), You have 60 days from the date of the qualifying event to enroll):

- You and/or Your eligible dependents lose coverage under another group or individual health benefit plan due to one of the following:
    - An employer's contributions to that other plan are terminated;
    - Exhaustion of federal COBRA or any state continuation; or
    - Loss of eligibility, for instance, due to legal separation, divorce, termination of domestic partnership, death, termination of employment or reduction in hours.

- You involuntarily lose coverage under Medicare, CHAMPUS/Tricare, Indian Health Service or a publicly sponsored or subsidized health plan (other than the Children's Health Insurance Program (CHIP), see below).
- You lose coverage under Medicaid or the Children's Health Insurance Program (CHIP).

For the above qualifying events, if enrollment is requested as specified, coverage will be effective on the day after the prior coverage ended.

If You are already enrolled or if You declined coverage when first eligible and subsequently have one of the following qualifying events, You (unless already enrolled), Your spouse (or Your domestic partner, except as noted) and any eligible children are eligible to enroll for coverage under the Plan within 60 days from the date of the qualifying event:

- You marry or begin a domestic partnership;
- You acquire a new child by birth, adoption, or Placement for adoption. NOTE: Your domestic partner is not eligible to enroll for coverage under the Plan in this situation; or
- You and/or Your dependent(s) become eligible for financial assistance under Medicaid or the Children's Health Insurance Program (CHIP).

For the above qualifying events, if enrollment is requested as specified, coverage will be effective on the first of the calendar month following the date of the qualifying event, except that where the qualifying

event is a child's birth, adoption or Placement for adoption, coverage is effective from the date of the birth, adoption or Placement.

ANNUAL ENROLLMENT PERIOD

The annual enrollment period is the only time, other than initial eligibility or a special enrollment period, during which You and/or Your eligible dependents may enroll. You must submit an enrollment form (and, in the case of a domestic partner, a completed affidavit of qualifying domestic partnership form) on behalf of all individuals You want enrolled. Coverage for You and Your enrolling eligible dependents will begin on the Effective Date.

DOCUMENTATION OF ELIGIBILITY

You must promptly furnish or cause to be furnished any information necessary and appropriate to determine the eligibility of a dependent. Such information must be received before enrolling a person as a dependent under the Plan.

When Coverage Ends

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

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

AGREEMENT TERMINATION

If the Agreement is terminated or not renewed, claims administration by Regence BlueShield of Idaho, Inc. ends for You and Your Beneficiaries on the date the Agreement is terminated or not renewed (except, if agreed between the Plan Sponsor and Regence BlueShield of Idaho, Inc., Regence BlueShield of Idaho, Inc. may administer certain claims for services that Claimants received before that termination or nonrenewal).

WHAT HAPPENS WHEN YOU ARE NO LONGER ELIGIBLE

If You are no longer eligible as explained in the following paragraphs, Your and Your Beneficiaries' coverage ends on the last day of the monthly period in which Your eligibility ends. However, it may be possible for You and/or Your Beneficiaries to continue coverage under the Plan according to the continuation of coverage provisions in this Summary Plan Description.

TERMINATION OF YOUR EMPLOYMENT OR YOU ARE OTHERWISE NO LONGER ELIGIBLE

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

NONPAYMENT
If You fail to make required timely contributions to the cost of coverage under the Plan, Your coverage will end for You and all Beneficiaries.

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

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

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

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

Persons entitled to coverage under this provision will not be entitled to any other extension of benefits described in this section for the same situation that entitles them to coverage under this provision. Entitlement to FMLA leave does not constitute a qualifying event for the purpose of COBRA continuation. However, a person who does not return to active employment following FMLA leave may be entitled to COBRA continuation coverage. The duration of that COBRA continuation will be calculated from the date the person fails to return from the FMLA leave.

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

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

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

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

WHAT HAPPENS WHEN YOUR BENEFICIARIES ARE NO LONGER ELIGIBLE
If Your dependent is no longer eligible as explained in the following paragraphs (unless specified to the contrary below), his or her coverage will end on the last day of the monthly period in which his or her eligibility ends. However, it may be possible for an ineligible dependent to continue coverage under the Plan according to the continuation of coverage provisions in this Summary Plan Description.

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

If You Die
If You die, coverage for Your Beneficiaries ends on the last day of the monthly period in which Your death occurs.

Termination of Domestic Partnership
If Your domestic partnership terminates after the Effective Date (including any change in status such that You and Your domestic partner no longer meet any of the requirements outlined in the definition of a dependent), eligibility ends for the domestic partner and the domestic partner's children (unless such children remain eligible by virtue of their continuing relationship to You) on the last day of the monthly period following the date of termination of the domestic partnership. You are required to provide notice of the termination of a domestic partnership within 30 days of its occurrence. You may not file another affidavit of qualifying domestic partnership within 90 days after a request for termination of a domestic partnership has been received.

Loss of Dependent Status
- For an enrolled child who is no longer an eligible dependent due to exceeding the dependent age limit, eligibility ends on the last day of the monthly period in which the child exceeds the dependent age limit.
- For an enrolled child who is no longer eligible due to disruption of Placement before legal adoption and who is removed from Placement, eligibility ends on the date the child is removed from Placement.

- For an enrolled child who is no longer an eligible dependent for any other cause (not described above), eligibility ends on the last day of the monthly period in which the child is no longer a dependent.

OTHER CAUSES OF TERMINATION
Coverage for the Plan Sponsor may be terminated for the following reason. However, it may be possible for Claimants to continue coverage under the Plan according to the continuation of coverage provisions in this Summary Plan Description.

Fraud or Misrepresentation
Coverage under the Plan is based upon all information furnished to the Claims Administrator, for the benefit of the Plan by You or on behalf of You and Your Beneficiaries. No statement made for the purpose of effecting coverage will void such coverage or reduce benefits unless such statement is contained in a written instrument signed by You.

Any intentional misrepresentation of material fact or fraud by the Plan Sponsor will result in termination of the Agreement.

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

COBRA Continuation of Coverage

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

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

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

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

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

General Rules
Generally, You or Your Beneficiaries are responsible for payment of the full cost for COBRA continuation, plus an administration fee, even if the Plan Sponsor contributes toward the cost of those not on COBRA continuation. The administration fee is 2 percent or, during any period of extension for disability, 50 percent.

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

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

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

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

Notice
The complete details on the COBRA Continuation provisions outlined here are available from the Plan Sponsor.

Other Continuation Options

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

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

Pregnancy
If the Plan provided for maternity benefits and a Participant, a Participant's female spouse or female domestic partner is pregnant at the time coverage under the Plan terminates and the Participant, a Participant's female spouse or female domestic partner is not eligible for any replacement group coverage within 60 days of the termination of Plan coverage, benefits will be provided under the Plan

for pregnancy, childbirth or miscarriage as detailed in this Summary Plan Description for a period not to exceed 12 months beyond the date of termination.

General Provisions

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

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

GOVERNING LAW AND DISCRETIONARY LANGUAGE
The Plan will be governed by and construed in accordance with the laws of the United States of America and by applicable laws of the state of Idaho without regard to its conflict of law rules. The Trustees delegate to the Claims Administrator discretion for the purpose of paying benefits under this coverage only if it is determined that You are entitled to them and of interpreting the terms and conditions of the Plan. Final determinations pursuant to this reservation of discretion do not prohibit or prevent a claimant from seeking judicial review of those determinations in federal court. The reservation of discretion made under this provision only establishes the scope of review that a court will apply when You seek judicial review of a determination of the entitlement to and payment of benefits or interpretation of the terms and conditions applicable to the Plan. The Claims Administrator provides claims administration under the Plan, and the court will determine the level of discretion that it will accord determinations.

TRUST IS YOUR AGENT

The Trust is Your agent for all purposes under the Plan and not the agent of Regence BlueShield of Idaho, Inc.. You are entitled to health care benefits pursuant to the Plan. In the Agreement, the Trust agrees to act as agent for You in acknowledging Your agreement to the terms, provisions, limitations and exclusions contained in this Summary Plan Description. You, through the enrollment form signed by the Participant, and as beneficiaries of the Plan, acknowledge and agree to the terms, provisions, limitations and exclusions described in this Summary Plan Description.

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

NOTICES
Any notice to Claimants or to the Trust required in the Plan will be considered to be properly given if written notice is deposited in the United States mail or with a private carrier. Notices to a Participant or to the Trust will be addressed to the Participant or to the Trust at the last known address appearing in the Claims Administrator's records. If the Claims Administrator receives a United States Postal Service change of address form (COA) for a Participant, it will update its records accordingly. Additionally, the Claims Administrator may forward notice for a Participant to the Trust if it becomes aware that it doesn't have a valid mailing address for the Participant. Any notice to the Claims Administrator required

in the Agreement may be given by mail addressed to: Regence BlueShield of Idaho, Inc., P.O. Box 2998, Tacoma, WA 98401-2998; provided, however that any notice to the Claims Administrator will not be considered to have been given to and received by it until physically received.

RELATIONSHIP TO BLUE CROSS AND BLUE SHIELD ASSOCIATION

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

REPRESENTATIONS ARE NOT WARRANTIES

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

CLAIMS ADMINISTRATOR IS NOT RESPONSIBLE FOR HEALTH SAVINGS ACCOUNT FINANCIAL OR TAX ARRANGEMENTS

While this high deductible health Plan was designed for use in conjunction with a health savings account (HSA), the Claims Administrator does not assume any liability associated with Your maintenance of an HSA during any period that this high deductible health Plan does not qualify for use with an HSA. You are solely responsible to ensure that this plan qualifies, and continues to qualify, for use with any HSA that You choose to establish and maintain.

The Claims Administrator assumes no responsibility for reimbursement from the custodial financial institution under any HSA with which this high deductible health Plan is used.

WHEN BENEFITS ARE AVAILABLE

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

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

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

WOMEN'S HEALTH AND CANCER RIGHTS
If You are receiving benefits in connection with a mastectomy and You, in consultation with Your attending Physician, elect breast reconstruction, coverage under the Plan will be provided (subject to the same provisions as any other benefit) for:

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

Definitions

The following are definitions of important terms used in this Summary Plan Description. Other terms are defined where they are first used.

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

Allowed Amount means:

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

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

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

Autism spectrum disorder means any of the pervasive developmental disorders or autism spectrum disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental

Disorders (DSM). In accordance with this guidance, “treatments for autism spectrum disorder” means medically necessary evidence-based care and related equipment prescribed or ordered for an individual diagnosed with an autism spectrum disorder by a licensed physician or a licensed psychologist who determines the care to be medically necessary, including but not limited to behavioral health treatment, pharmacy care, psychiatric care, psychological care, and therapeutic care.

Treatments for autism spectrum disorder are to be considered part of Idaho’s Essential Health Benefits (EHB) package under mental health services including behavioral health treatment; and therefore the coverage of such treatments under this plan: will be consistent with other mental health services (including applicable deductibles, copayments, or coinsurance), not subject to any separate dollar limits or visit limits, and in parity with medical and surgical benefits.

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

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

Claimant means a Participant or a Beneficiary.

Claims Administrator is a person or entity, if other than the trustee, employed or contracted by the Trust to provide claims administrative services to a self-funded plan. The Claims Administrator is Regence Blue Shield of Idaho, Inc.

Congenital Anomaly means a condition existing at or from birth that is a significant deviation from the common form or function of the body, whether caused by a hereditary or developmental defect or disease. For the purpose of this definition, 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.

Covered Service means a service, supply, treatment or accommodation that is listed in the benefits sections in this Summary Plan Description.

Custodial Care means care that is for the purpose of watching and protecting a patient, rather than being a Health Intervention. Custodial Care includes care that helps the patient conduct activities of daily living that can be provided by a person without medical or paramedical skills and/or is primarily for the purpose of separating the patient from others or preventing self-harm.

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

Effective Date means the date Your coverage under the Agreement begins after acceptance for enrollment under the Plan.

Emergency Medical Condition means a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson who has an average knowledge of

medicine and health would reasonably expect the absence of immediate medical attention at a Hospital emergency room to result in any one of the following:

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

Essential Benefits are determined by the U.S. Department of Health and Human Services ("HHS") and are subject to change, but currently include at least the following general categories and the items and services covered within the categories: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services including oral and vision care.

Family means a Participant and his or her Beneficiaries.

Health Intervention is a medication, service or supply provided to prevent, diagnose, detect, treat or palliate the following: disease, Illness, Injury, genetic or Congenital Anomaly, pregnancy or biological or psychological condition that lies outside the range of normal, age-appropriate human variation; or to maintain or restore functional ability. A Health Intervention is defined not only by the intervention itself, but also by the medical condition and patient indications for which it is being applied. A Health Intervention is considered to be new if it is not yet in widespread use for the medical condition and the patient indications being considered.

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

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

Illness means a congenital malformation that causes functional impairment; a condition, disease, ailment or bodily disorder, other than an Injury; and pregnancy. Illness does not include any state of mental health or mental disorder (which is otherwise defined in this Summary Plan Description).

Injury means physical damage to the body inflicted by a foreign object, force, temperature or corrosive chemical or that is the direct result of an accident, independent of Illness or any other cause. An Injury does not mean bodily Injury caused by routine or normal body movements such as stooping, twisting, bending or chewing and does not include any condition related to pregnancy.

In-Network means a Provider that has an effective participating contract with the Claims Administrator that designates him, her or it as a network Provider, who is a member of the Plan Sponsor's chosen Provider network, to provide services and supplies to Claimants in accordance with the provisions of this coverage. In-Network also means a Provider that has an effective participating contract with one of the Claims Administrator's Affiliates or a Provider outside the area that the Claims Administrator or one of

its Affiliates serves, but who has contracted with another Blue Cross and/or Blue Shield organization in the BlueCard Program (designated as a Provider in the "In-Network") to provide services and supplies to Claimants in accordance with the provisions of this coverage. If the Claims Administrator or one of its Affiliates has more than one Provider network from which the Plan Sponsor may choose for benefits under the Plan, then the Providers contracted under the network selected by the Plan Sponsor will be considered the only In-Network Providers for purpose of payment of benefits under this Summary Plan Description. For In-Network Provider reimbursement, You will not be charged for balances beyond any Deductible and/or Cost Sharing for Covered Services.

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

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

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

Medically Necessary or Medical Necessity means health care services or supplies that a Physician or other health care Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an Illness, Injury, disease or its symptoms, and that are:

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

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible Scientific Evidence published in Peer-Reviewed Medical Literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians and other health care Providers practicing in relevant clinical areas and any other relevant factors.

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

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

Out-of-Network refers to Providers that are not In-Network. For reimbursement of these Out-of-Network Provider services, You may be billed for balances over the Claims Administrator's payment level in addition to any Deductible and/or Cost Sharing amount for Covered Services provided inside or outside the area that the Claims Administrator or one of its Affiliates serves.

Participant means an employee of the Plan Sponsor who is eligible under the terms described in this Summary Plan Description, has completed an enrollment form and is enrolled under this coverage.

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

Placed or Placement means physical Placement in the care of the adoptive Participant. In those circumstances in which such physical Placement is prevented due to the medical needs of the child requiring placement in a medical facility, it means when the adoptive Participant signs an agreement for adoption of such child and signs an agreement assuming financial responsibility for such child.

Plan Sponsor is any person who creates a self-funded health benefit plan for the benefit of any employer and employee or employees. In this case, the Plan Sponsor is the City of Chubbuck.

Practitioner means an individual who is duly licensed to provide medical or surgical services which are similar to those provided by Physicians. Practitioners include podiatrists, psychologists, certified nurse midwives, certified registered nurse anesthetists, dentists (doctor of medical dentistry or doctor of dental surgery, or denturist; and a dental hygienist who is permitted by his or her respective state licensing board, to independently bill third parties) and other professionals practicing within the scope of his or her respective licenses.

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

Rehabilitation Facility means a facility or distinct part of a facility that is licensed as a Rehabilitation Facility by the state in which it is located and that provides an intensive, multidisciplinary approach to rehabilitation services under the direction and supervision of a Physician.

Regence refers to Regence BlueShield of Idaho, Inc.

Scientific Evidence means scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their

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

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

Summary Plan Description (SPD) is a summary of the benefits provided by the Group Health Plan (GHP). A GHP with different benefit plan options may describe them in one SPD or in separate SPDs for each alternative benefit plan option.

Trust is a trust fund established in conjunction with a self-funded plan for receipt of contributions of employer and employees and payment of or with respect to health care service costs of beneficiaries. In this case, the name of the trust is the City of Chubbuck Health Plan Trust.

Trustee is the trustee, whether a single or multiple trustee, of the trust fund.